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ABSTRACT

The manual is intended to provide preschool educators who work with exceptional children with both theoretical background and practical guidance in teaching children with attentional deficit disorders, oppositional disorders, conduct disorders, autism, developmental learning disorders, childhood depression, borderline personality disorders, and childhood schizophrenia. The first chapter presents information on the normal child including motor development, perceptual development, language acquisition, and social and emotional development. Charts of age appropriate norms from ages 2 through 5 are provided. Among 10 charts given in the extensive chapter on the special child are a temperament checklist, a self-concept rating scale, a chart of basic developmental tasks, language milestones, and indicators of possible learning disorders. A chapter is then given to each specific disability area organized around theoretical considerations, student characteristics, causation and prognosis, and treatment and management. Suggested readings are provided for each chapter and a glossary of terms is also included. (DB)

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THE SPECIAL CHILD

Strategies
for
Treatment and Management

understanding and guiding to reach
Individual Potential

Mickie Ellis

Early Childhood Specialist

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THE SPECIAL CHILD

Strategies
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MICKIE J. ELLIS

to **Nancy** for her help and encouragement.
to **Thanil, Teddy and Gareth...** living
wondrous proof of the beauty of childhood.

Cover design

Nancy Ellis

PREFACE

Anyone who sets out to write on the exceptional child faces a challenge. Simply keeping up with new knowledge, research and treatment (management) methods is a tremendous job.

This little manual (and it seems to grow smaller as the task overwhelms) is an attempt to provide summarized and concise theoretical background to promote some understanding of the problem, practical suggestions for handling the child in a group situation and symptoms or presenting problems (behaviors) which may be helpful in making a decision to have the child assessed.

My original idea was to cover the whole gamut of difficulties in the preschool child. However, I now agree with some kindly advice which pointed out the "ambitiousness" of such a project and have since touched base with reality. I will put aside for my next book, fear and anxieties, dyslexia, gender disorders, obsessive-compulsions, physical disorders and the many syndromes of childhood not to mention the more "casual" difficulties of young children. The present book covers only a few of the problems as diagnosed through formal assessment and represent children who are desperately in need of help and encouragement.

I present this information with the Early Childhood Educator particularly in mind. The lack of such a ready reference has, in my opinion, been a missing link. My close association with these educators over the years has confirmed for me their dedication, caring and willingness to go that extra mile for the child and his/her family. Only recently (and only partially and tentatively) has consideration been given to providing more practical support to the field of E.C.E. With this manual as a reference, together with workshops and "hands-on" demonstrations, hopefully one more resource will be available.

In reviewing the producing of this work there are many who have contributed and helped. There are a few without whose help the task would never have been accomplished. Dr. Polly Peterson provided excellent advice and practical suggestions, Jon Boyd's enthusiasm, encouragement and proofreading were much appreciated. Thanks go to my daughter Nancy who was always there to give that extra push and has provided a lovely design for the cover. Thanks also to Maria and Suzanne who helped out with typing. The person to whom I am really indebted is Cheryl McCorriston who never failed to help with format (and spelling!) and who quietly "hung-in-there" when the pressure of deadlines were often overwhelming. Finally, I must acknowledge the children, who over the years, have contributed to my store of knowledge and experience.

Mickie J. Ellis

TABLE OF CONTENTS

Page

PART I INTRODUCTION

Chapter 1 The Normal Child....................................2
Chapter 2 The Special Child....................................18

PART II BEHAVIORAL DISORDERS

Chapter 3 Attentional Deficit Disorder..........................95
Chapter 4 Oppositional Disorders..............................107
Chapter 5 Conduct Disorders...................................114

PART III DEVELOPMENTAL DISORDERS

Chapter 6 Autism in Young Children............................122
Chapter 7 Developmental Learning Disorders....................141

PART V PERSONALITY AND EMOTIONAL DISORDERS

Chapter 8 Childhood Depression................................155
Chapter 9 Borderline Personality Disorders....................164
Chapter 10 Childhood Schizophrenia.............................177

PART 1

INTRODUCTION

CHAPTER 1

THE NORMAL CHILD

1 THE "NORMAL" CHILD

Volumes have been written on the normal development of the child. Piaget's (1926) contribution on the intellectual and cognitive journey in a child's life organized his own (and others) works and research into readily understandable stages through which all children progress albeit at their own individual time.

The psychological (emotional) development was given far less attention despite the fact that work in this field goes all the way back to Seigmund Freud (1915). Freud's **Inhibitions, Symptoms and Anxieties** along with his revelations on the id, ego, superego, oral, anal and phallic stages of development were invaluable contributions. Adler (1907-1937) provided insight into the child's feelings of inferiority and insecurity, the striving for self-enchantment and the need for affection.

As we progress along the continuum of writings on child development, we have John Bowlby's theories (1969) on separation and loss (Attachment: Anxiety and Anger); Winnicott's (1952) theory on anxiety (associated to insecurity); Ainworth's (1973) and Brazelton's (1961) writings on infant care and the growth of love; Elkind's (1979) child development theories; Koblberg's (1976) moral stages and the development of moral character; Mahlers (1975) expansion on the psychological birth of the child (stages of autism, separation, individuation, and object constancy); Minuchin and Shapero (1983) on social development and Thomas and Chess' (1977) important findings on temperament and development. A quick glance at the literature will confirm that only a few contributors to our wealth of knowledge on child development have been cited and refers generally to "normal" development and stages. In considering exceptionalities, children suffering from disorders of development, behavior, physical or emotional growth, they must be considered in relation to normal child development. How children learn, how they are socialized to control aggression, help us in our understanding of the troubled child. The impact of interactions between nature, nurture, biology and environment are forever overlapping and interacting.

While chronological growth follows certain steps and stages, environmental factors may influence the direction of development. On the other hand it has been said that "organismic peculiarities may block, weaken or heighten the impact of environmental stimuli or impose idiosyncratic structure upon them." The measurement of a child's development in terms of height, weight, language acquisition, motor capacity and intellectual performance, subjective changes in feeling, attitudes and perceptions is a more inclusive concept than chronological age (only one facet among many that contributes to developmental status).

Attempts to isolate genetic and environmental influences may be futile for many areas of development. We now know that prior to birth the infant develops through the interaction of his unborn characteristics and the uterine environment. Little imperial data has been found in terms of measurable indicators of environmental factors that provide information on personality types or developmental patterns. We do know that extremely deviant backgrounds produce deviant personality development. The nature and quality of experience has an important impact on the developmental process.

The make up of an individual's genes (with the exception of identical twins) determine that individual's psychological, biochemical and anatomical growth and development. A child's constitutional endowment is the foundation on which the child's personality develops and how the individual interacts with the world. How the child interacts with others and conversely their influences on him is an added factor in the development of personality.

Let us consider specific areas of normal development in the young child.

Motor Development

Usually a sequence of orderly stages beginning at 3-4 weeks with postural control of the neck and ends with walking at 18 months.

Individuals follow their own time line in maturing motorically and appears to be independent of learning and stimulation but may be more dependent on good health and nutrition.

Control of muscles proceed from proximal (gross) to the distal (fine) sections. It begins with the infant reaching for objects and is the prerequisite for self help skills, control and coordination of the lower extremities, acquisition of expressive speech in terms of vocal-motor development. Handedness develops slowly and may not be completely established until approximately 6 years of age. Motor can be influenced by practice, some skills must be taught such as skiing, roller skating, etc.

Perception

When we talk about perception we are referring to the processing of sensory information through the central nervous system. Several variables are at works: type of stimuli; sensory organs, intelligence of the child.

Visual Perception (Memory)

Sensations are received from touching objects and integrated with visual stimuli to give a clearer picture. Body orientation and spatial relationships are the earliest visual processing tasks of an infant. Later children begin the identification of left/right and tasks requiring construction of patterns.

Auditory Perception

It is quite probable that the unborn baby hears and responds in some way to environmental sounds. It has been established that newborns have a functioning hearing ability. Auditory perception is the ability to select and organize pertinent auditory stimuli. This ability does depend on a functioning auditory apparatus and an intact auditory cortex.

Haptic Perception

The haptic system is made up of pain, touch, temperature and the sensation of muscle movement. The knowledge of qualities, of size, texture, consistency, temperature, shape, hardness, form, orientation in space and location of parts of the body is necessary for survival. Limited attention had been given to these processes to date. It is now believed that tactile recognition is a process of maturation which is usually achieved by approximately seven years of age.

Multi-Sensory Integration

Information from the senses must be integrated for a child to obtain a complete picture of the object world. Even normal children may have difficulty responding to two or more systems simultaneously.

Self Perception

Body image is gradually acquired. Internal and external sensations as well as motor activities are the raw materials out of which a sense of self is built. This image is important in terms of "assigning meaning and significance" to his experience.

Language Acquisition

Babies can distinguish between sounds. They especially like baby talk. They usually begin acquiring words by their first birthday beginning with one word progressing to two word telegraphic imitations. By the time they are five they have vocabularies of six to ten thousand words, which reflect symbolic thought. Language development depends on innate abilities and environmental input.

Social and Emotional Development

As 2 and 3 year olds, children's play is mainly parallel and ritualistic. Four year olds use language and engage in pretend, cooperative and interactive play. Young children are sometimes social but often engage in antisocial behavior such as fighting, hurting or being verbally unkind. Aggressive behaviour can stem from many sources - frustration, imitation, television, basic traits or feeling of low self-esteem. Their self-concepts may be based on sketchy, often inaccurate perceptions.

Boys and girls begin to act differently by the time they are three years old - girls play house, are more attuned to feelings while boys are into power games and fantasies and are more likely to be aggressive than girls. Also at this age, children become somewhat knowledgeable about sex constancy, gender roles and proceed to developing their gender identity.

SUMMARY

Many important writers down through the ages have contributed to our knowledge of the developing child. We now know that the unborn infant has progressed through considerable important stages. Infants develop motor skills in the same sequence as the unborn child. Motor milestones, visual development and general growth are acquired at individual rates and are a result of heredity and environmental conditions.

As children develop they acquire speech (symbolic thought), motor agility, memory abilities, cognition, social and emotional competence.

SUGGESTED READING

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AGE APPROPRIATE NORMS

2-3 YEARS

General/Temperament/Attitude

Insist on routines being followed.
Clings to favorite possession when insecure.
May cling to old clothes and dislike new ones.
Selfish, possessive, aggressive, contrary.
Rigid and inflexible -- cannot adapt. (2 years)
Domineering and demanding.
Can't choose alternatives and perseverates.
Doesn't need rituals.
No longer rigid, inflexible, domineering. (3 years)
Pleased with self and secure.

Interpersonal

Brings favorite toy to school to show but doesn't want to show it.
Has more disputes with others than at any other age.
Sudden aggressive attacks - may hit stranger.
Selfish, possessive, can't share or wait.
May form a close attachment for teachers.
Clings tightly in affection, fatigue or fear.
Defends own possessions with determination.
Has no idea of sharing.
Resentful of attention shown to other children.
Likes to please others occasionally.
Can substitute toys for other children.

Play Behavior

Identified self in mirror.
Prefers solitary play.
Plays interactive games such as tag.
Parallel play predominates.
Initiates own play activities.
Enjoys simple group activities (e.g., ring around rosy).
Finger paints and clay.
Enjoys marked rhythm of band music and will respond.
Plays at being an animal or baby or may imitate adult.
Enjoys looking at books alone.

Family Relations

Has difficulty with siblings as with everyone else - can't wait or share.
Sibling jealousy.
Does opposite of what everyone wants.
May tease older siblings, break and spoil their things, then cry if they retaliate.
Variable response to younger siblings.
Separates from mother easily.
Likes to visit relatives.

Tension Releasers (Outlets)

Thumb sucking less during day- associated with hunger, frustration, fatigue.
Many presleep demands.
Some masturbation.
Stuttering.

AGE APPROPRIATE NORMS Cont'd:

Age 2-3 Years

Sudden aggressive attacks.
Temper tantrums.

Sleeping/Dreams

May dream - commonly of trains.
Play naps - goes to sleep quickly and wakes pleasantly.
Middle of night activities (especially pigs and things under bed).
Report dreams and may be awakened by them.

Sexual Concerns

Child shows interest in different postures of boys and girls when urinating.
Child is interested in physical differences between sexes.

Language

Can respond to simple requests.
Understands common nouns/verbs.
Can label pictures in book (3).
Has a vocabulary of 25-50 words.
Uses 2-3 word phrases.
Can verbalize needs e.g., food/toilet.
Understands simple concepts (on, to, in).

Fears

Many fears: mainly auditory (trains, trucks, thunder, toilet, vacuum).
Visual fear (dark colors, large objects; trains, hats).
Spatial: toy or crib moved from usual place, moving to a new house, fear of going down drain.
Personal: mother's leaving or separation from her at night.
Rain and wind.
Animals - especially wild, eg. lions, tigers.
Fears someone entering house by different door.
Going into bedroom alone at night.
May need night light.

Attention & Memory

Delayed memory, follows transfer of objects and knows where to find them.
Recognizes the names and pictures of most common objects.
Carries out three simple verbal commands.
Listens to a short story.

Motor Abilities

Gross

Jumps and runs well (occasional falling).
Squats while playing (no hand support).
Walks up and down stairs with rail (both feet on same step).
Runs without falling.
Throws or kicks large ball.
Jumps with both feet.
Hops on one foot.
Rides toys on wheels by pushing himself.
Climbs up on box, step-stool, etc.
Uses climbing equipment.

Fine

Builds tower of 8 cubes.
Imitates vertical and horizontal strokes.
Strings beads.
Cuts with scissors (not necessarily correctly).
Removes coat or dress (not unbuttoning).
Holds crayon appropriately, usually.
Puts on shoe (not tying).

Age 2-3 Years

Will feed self with little spilling.

Self Help Skills

Feeds self, with some spilling.
Uses straw.
Begins to use a fork.
Knows differences between edible and not edible substances.
Dries hands without help.
Asks to go to the bathroom during the day, often late.
Puts on shoes and boots with help.
Dresses self with help.
Uses bathroom regularly for bowel movements.
Gets drink without help.
Washes hands and face with help, using soap.
Hangs up coat with help.
Takes off most clothing.
Uses napkin, not perfectly.
Pores from a small pitcher.
Helps while being bathed.
Knows the difference between bladder and bowel function.

Social Skills

Solitary play gives way to parallel play, no real exchange or sharing.
Beginning of associative play (do things in groups - no division of labor or organization to play).
Projects independence (at times) in social situations.
May participate in grim, wordless tug-of-war over toys (may end in crying and screaming).
Needs to be loved and accepted for self.

AGE APPROPRIATE NORMS

3-4 YEARS

General Characteristics

Dawdles.
Insecurity extremes -- shy and boisterous.
Asks "How" and "Why" questions.
Shocking language, defiant.
Wild imagination.
Overly secure and brash.

Interpersonal

Likes to help with adult activities.
Quarrels occur frequently but are usually solved with minimal adult interference.
Performs for others.
Wishes to please - likes to give and share.
Can enjoy doing things someone else's way.
Likes to make friends.
May listen to reason and modify behavior.
In group situation relates first to adult and later to children.

Play Behavior

Understands taking turns.
Vivid imagination play including invented people and objects.
Listens eagerly to stories and demands favorites over and over.
Enjoys floor play with bricks, boxes, trains and cars alone or with siblings.
Join in play with other children (1 or 2) but may still play alone often.
Interactive games replace parallel play.

Family Relations

Shows affection for younger sibling.
Rough with siblings and quarrelsome.
May be jealous of parents.
Change from favoring mother to favoring father.
Brags and boasts about home and family.

Tension Releasers

May wander around house at night.
Increase in tensional outlets.
Thumb sucking at night with accessory object - in day time without object.
Spitting.
Nose picking, fingernail biting.
Hands may tremble and child may stumble and fall.
Whining.

Sleeping/Dreams

Does at lot of dreaming and may be disturbed by it but is easily quieted.
Ready to try new experiences and give up old pattern - good time to move to a big bed.

Sexual Concerns

Beginning of interest in babies-child wants family to have one, asks where they come from.
May have confused idea about babies, cannot fully understand

Age 3-4 Years

whole concept.
May believe you buy a baby as you would groceries.
Girls attempt to urinate standing up.

Language

Common expression is "I did".
Vocabulary has innumerable words; he speaks in well-formed simple sentences.
Uses some plurals.
Vocabulary in excess of 900 words.
Names pictures, and on request tells the action, e.g. "baby is sleeping."
Knows a few rhymes (Little Bo-Peep; Miss Muffet, etc.).
Names eight pictures correctly (cup, kitty, shoe, house, flag, clock, star, leaf, basket, book).
Tells sex correctly in response to "are you a little boy or a little girl?"
Comprehension of one question. "What must you do when you are sleepy?" (Hungry, cold).
Preposition directions (can respond to at least two).

Fears

Visual fears predominate (masks, strange looking people).
Dark.
Policeman, burglars.
Mother or father leaving at night.

Attention & Memory

Repeats four phrase sequences.
Repeats four digits.
Follows sequence of three directions correctly.
Can reproduce simple designs from memory.
Draws a three part man from memory.

Motor Abilities

Can walk on tiptoe.
Can run on toes.
Pedals tricycle.
Can jump on both feet.
Upstairs alternating feet.
Throws ball with direction.
Swings on swing independently.
Slides on slide.
Forward somersault with aid.
Jumps from height of 12".
Builds 9 block tower.
Imitates horizontal stroke.
Imitates circular stroke.
Picks up small objects.
Handles crayon in adult manner.
Good at puzzles.
Imitates cross.

Self Help Skills

Holds fork correctly.
Usually feeds self entire meal.
Cleans nose when reminded.
Begins night bladder control.
Unbuttons clothing.
Frequently begins dressing and undressing self.
Puts on shoes and boots with instructions.
Cleans up spills with help.
Cares for daytime toileting needs.
Hangs up coat with instructions.
Pulls shoe laces tight.
Serves self with help.
Brushes teeth with help.
Buttons large buttons.
Cannot tie shoes - shows interest.

AGE APPROPRIATE NORMS Cont'd:

Age 3-4 Years

Social Skills

Beginning of cooperative play.
Marked sense of belonging to a group.
Interactions increase, quarrels decrease.
May attack belongings of other children.
Begins to make more decisions.
Precarious balance between cooperation and willfulness.

AGE APPROPRIATE NORMS

4-5 YEARS

General Characteristics

Tends to go out of prescribed bounds.
Not so lost in fantasy--questions reality of imagination.
Self-motivation emerges.
Better attention span and follow-through.
Interest in detail and discussion.
Better able to accept frustration.
Enjoys story telling.
Enjoys humor.
Reliable, stable and well adjusted.

Interpersonal

Tattles, calls names.
Proud of possessions.
Needs other children to play with and is alternatively co-operative and aggressive as with adults.
Shows off dramatically.
Bosses and criticizes.
Shows sympathy for playmates in distress.
Enjoys supervision.

Play Behavior

Leaders and followers emerge in play - child becomes aware of his role in group.
Exclusion from play along sex lines.
Enjoys using costumes and props.
Not ready for much organization-needs free acting and outdoor play.
Beginning to understand rules and turns.
May state rules but does not always observe them.
May think of teddy bear as real person.
Can stay with an absorbing activity.
Imaginary companions.

Family Relations

Mother is center of child's world and likes to be near.
May strike at parents in anger.
Interest in having a baby.
Proud of father and may obey more readily than mother.
Protective, kind and responsible toward younger brothers and sisters.

Tension Releasers

Thumb sucking only as going to sleep.
Out-of-bounds behavior and runs away, kicks, spits, boasts, name calling.
Nightmares and fears.
Needs to urinate when emotionally excited.
Pains in stomach and may vomit under stress.

Sleeping/Dreams

Sees dreams as real.
Stimulated by other children and may need help to settle down at nap time such as music or stories.

Sexual Concerns

Extremely conscious of the navel.
Under social stress may grasp genitals and need to urinate.
Verbal play about elimination.

May play game of "show".

Interest in other people's bathrooms and bath room activities of others.

May demand bathroom privacy for self.

Asks how babies get out of mother's "tummy" - may think baby is born through navel.

Language

Relates experiences.

Gives simple accounts of experiences or tells stories (unprompted) with sequential and coherent content and relevant detail.

Names all primary colors when shown.

Counts three objects, pointing to each in turn.

Names objects from memory.

Reads and tells a familiar story by way of pictures. ("Three Bears", etc.)

Vocabulary in excess of 1500 words.

Opposite analogies. eg: Brother is a boy; sister is a ______.

Number concept of 2.

Object identification through function.

Carries out four individual commands using prepositions.

Fears

Auditory fears - especially sirens.

Not a fearful age - mainly visual fears.

Concrete fears - bodily harm, falling, dogs.

Attention & Memory

Remembers six parts in the human drawing.

Repeats back five to six phrase sentences.

Follows a sequence of four directions correctly.

Repeats correctly, sequence of five to six digits.

Motor Abilities

Downstairs alternating feet last few steps.

One foot standing, 4-8 seconds.

Can walk backwards.

Hops.

Gallops.

Leaps.

Jumps forward 10 times without falling.

Bounces large ball.

Begins to skip.

Somersaults without aid.

Copy a triangle.

Pick up block with thumb and median finger.

Folds paper 3 times with creases.

Draws without scribbling and names drawing.

"Drawing" takes on form.

Copy a square.

Builds a pyramid with blocks in imitation.

Attempts to copy a diamond.

Self Help Skills

Clears place at table.

Cleans up spills without help.

Washes hands and face without help.

Bladder control at night.

Puts on shoes and boots without help.

Keeps nose clean without help.

Bathes self with supervision.

Uses knife for spreading.

Uses knife for cutting with help.

Dresses self completely, zips and

Age 4-5 Years

buttons.
Makes imperfect knot.
Serves self.
Helps set table.
Brushes teeth without help.
General independence with toileting.
Combs hair with help.
Goes about neighbourhood without constant supervision.

Social Skills

More civilized verbalizations in resolving conflict.
Aggressive talk rather than physical attach.
Able to wait turn, take direction from others.
Begins to explore "what kind of person he is" often characterized by aggressive behavior, usually unintentional.
Flowering imagination (may frighten self).
Tries out adult roles.
Beginning of feeling of right/wrong, guilt.
May blame other children for things he does not fully understanding (should not be seen as "lying" or be assigned too much guilt).

CHAPTER 2

THE SPECIAL CHILD

The previous brief descriptions of normal development of the normal child was presented as a background in considering the special or exceptional child. Exceptional children are those children who require special treatment, programming or education. This manual will not cover all serious deficits of young children however, the ones under discussion will be markedly different in one or more of the following categories: behaviorally, developmentally, emotionally or physically. An in-depth look at the course, cause, and prognosis will hopefully shed light on the treatment plan most suited to each individual child's need.

While many problems experienced by young children came under the heading of "severe", there are other children (far greater in number) who present with troublesome behaviors but who manage to "hang in there" when in fact they too are crying out for help and encouragement. The child who is somewhat aggressive, extremely shy, withdrawn, loud or busy, the child who can't seem to attend, or who shuns the limelight may need only an extra dose of acceptance, encouragement or a boast in self esteem to really make the difference.

Children may reveal their unhappiness, frustration, etc., by talking about their feelings or by behaviors such as aggression, fantasy, day-dreaming, negativism, unco-operativeness, fearfulness, bossiness, withdrawal. In looking at behavior as indicators of problem areas let us consider some of the ones mentioned above. When frustrations are imposed on a child by his parents (on whom he is dependent for his basic physical needs, or by a teacher who is a significant other) a conflict may arise. The child may repress his feelings of hostility toward all adults. Although some repression is part of growing up, the child who cannot verbalize or release hostility in acceptable ways may use up the energy he needs for learning in trying to keep his true feelings hidden. Sometimes the hidden feelings become redirected against others in the environment. For example, a boy who is scolded unjustly for something his sister or friend did may take out his resentment in the school situation by refusing to enter into activities or to do the tasks planned for him.

Another form of escape can be found in fantasy and day-dreaming. Make believe satisfactions may be substituted for the real satisfactions that are lacking in his world. Some daydreaming is normal. Younger children normally engage in some magical thinking and use this make-believe to try out life roles. However, the child who prefers daydreaming to real-life interactions may be overusing this coping device because his life is so unrewarding. A good example is the child who prefers to stare out the window when there are exciting activities going on in the playroom. A child who consistently withdraws from social interactions will probably be unfulfilled in terms of his need to belong.

The child who is experiencing tension often resorts to an earlier developmental level (immaturity) to find comfort and avoid frustration. For example, the child who is feeling unhappy about the lack of attention because of a new baby in the home may suddenly seek the help of the teacher in putting on his coat. This is a normal behavior which becomes a problem only if it persists. These are a few of the examples of behaviors which children use in trying to cope with an environment which may be threatening or difficult.

It is hoped that the following check lists on temperament, self concept, activity level and particularly the individual child profile (observational survey) will not only help you pin-point the children who need a referral and an in-depth assessment but will also assist in helping with those children who need that little bit extra. Children who suffer from low-self esteem for whatever reason are at a great disadvantage. Their feelings of incompetence and worthlessness can lead to many troublesome behaviors such as aggression, withdrawal and even depression. The "Basic Tasks" chart can be helpful in working with any child who is experiencing gaps in development. It is particularly appropriate for ADD, DLD and autistic children.

1. Temperament Checklist
2. Self-Concept Rating Scale
3. Basic Tasks
4. Individual Child Profile (Observational Survey)
5. Behavioral Questionnaire
6. Social Competency Check List
7. Social-Emotional Growth
8. Language Milestones
9. Indicators of Possible Learning Disorders (3 and 4 years)
10. Individual Program Planning Forms

SUMMARY

To really know the children with whom you work takes more than casual involvement. It is relatively simple (and important) to spot the child with a serious problem. Although careful checking is also necessary, it may be the child on the edge of things, the one who barely scrapes by that is in need of a second look. Several tools for a quick screening are offered throughout as a means of taking "that second look" at both the severely affected child and the child with questionable behaviors or difficulties.

SUGGESTED READING

Buss, A.H. and Plomin, E., A Temperament - Theory of Personality Development. John Wiley & Sons: New York.

Greenspan, S.I. (1981). Psychopathology and Adoption in Infancy and Early Childhood. International Press: New York.

Segal, J., and Yahraes, (1978). A Child's Journey. McGraw-Hill: New York.

Stern, D.N. (1985). The Interpersonal World of the Infant. Basic Books: New York.

Thomas, A., and Chess, S. (1980). The Dynamics of Psychological Development. Brunner/Mozel: New York.

TEMPERAMENT CHECKLIST

1 high	2 moderate	3 low
EMOTIONALITY		
I) General intensity of reaction		
easily agitated or upset; cries easily	excited or upset only when appropriate to situation	almost always calm, easygoing
II) Fear		
appears nervous, insecure, easily frightened	expressions of fear only occasionally and when expected given the situation	almost never appears frightened or nervous
III) Anger		
easily annoyed; strikes out at other children; screams or yells	expressions of anger only occasionally and when elicited by situation	almost never hits other children or yells
IV) Control		
out of control; no attempt to control emotional expression	degree of control approximates that of expected age group	highly controlled; indicators: facial expression, posture, no screaming, physical aggression
V) Mood		
extreme mood swings; highly reactive to situations, internal states	generally positive moods, indicates negative reactions when appropriate	flat affect, negative, lacks expression of feelings, depressed
ACTIVITY		
I) Tempo		
moves rapidly from location to another; always on the go; activities are fast paced	activities and movements are moderately paced	remains in one place for long periods of time; needs encouragement/help to move from one activity to another

TEMPERAMENT CHECKLIST Cont'd:

	1 high	2 moderate	3 low
II) Vigor	prefers more active games; movements are forceful and energetic	no marked preference for either active or passive games	prefers more quiet, passive games; movements are somewhat lethargic
SOCIABILITY			
I) Approach or withdrawal	prefers to play with others; non-discrimative response to strangers	play includes episodes of both peer interaction and and solitary play	prefers to play by himself; avoids strangers
II) Warmth	affectionate toward peers (e.g. high frequency of smiling at others) very frequently makes social overtures; attends to needs of others (e.g., offers instrumental help)	friendly in response to overtures from others; occasionally makes social overtures	typically aloof from others
IMPULSIVITY			
I) Persistence and attention span	works at task or game until completed or for long period of time; continues activity in face of obstacles; not easily distracted from activity	attends to activity for about average period of time; may occasionally be distracted from activity by external stimuli	flits from one activity to another; easily distracted or discouraged from completing activity
II) Inhibitory control	displays difficulty in waiting; low tolerance in frustrating situation; little self-control	delays gratification to same extent as most other children his age; tolerates a moderate degree of frustration	waits patiently; tolerates a frustrating situation; high degree of self-control

SELF-CONCEPT RATING SCALE

Child's Name ______________________________

Date ____________________________ **Examiner** ______________________

Please rate each item by indicating one number on the following child-adult scale.

Section 1 - Feeling Generated in the child

1 - Low **2 - Moderate** **3 - Severe**

	1	2	3
Aggression	_	_	_
Creativity	_	_	_
Achievement	_	_	_
Indifference	_	_	_
Co-operation	_	_	_
Failure	_	_	_
Withdrawal	_	_	_
Belonging	_	_	_
Tension	_	_	_
Hostility	_	_	_
Enthusiasm	_	_	_
Submissiveness	_	_	_
Fear	_	_	_
Success	_	_	_
Interest	_	_	_
Guilt	_	_	_
Identification	_	_	_
Curiosity	_	_	_
Trust	_	_	_

Section 2 - Cues from Significant Adults

	1	2	3
Acceptance	_	_	_
Ridicule	_	_	_
Concern	_	_	_
Sarcasm	_	_	_
Encouragement	_	_	_
Reflection	_	_	_
Security	_	_	_
Annoyance	_	_	_
Empathy	_	_	_
Anger	_	_	_
Sensitivity	_	_	_
Discouragement	_	_	_
Understanding	_	_	_
Impatience	_	_	_

BASIC TASKS

Area of Deficit	Task (Demonstrate)	Instruction	Skill Acquired	Date	Comments
Motor Development: The development and awareness of muscle activity.					
Note: Cannot "copy" demonstrations - it will be necessary to help him with these tasks along with illustrations. Each task will need to be expanded on and in many cases step by step task analysis will be required. (May have to start at a lower level.)					
Rolling: The ability to roll one's body in a controlled manner.	From a supine position, with arms over head, child can roll from back to stomach. Child can do sequential rolling to right and left, can roll down hill or incline.	Child lies on back with arms over head and feet together. Roll over slowly to right. Roll over slowly to left.			
		Child puts one arm straight over head and other arm down by side. Roll to right 3 times. Roll to left 3 times.			
Crawling: The ability to crawl on hands and knees in a smooth and co-ordinated way.	With eyes fixated on target, child first crawls in a homolateral fashion. Child progresses to cross-lateral crawling program. Under over objects, etc.	Child crawls on the floor moving arm and leg on the same side together (homolateral).			
		Child crawls on the floor fast like a dog, moving opposite arm and leg together (cross lateral).			

BASIC TASKS

Area of Deficit	Task (Demonstrate)	Instruction	Skill Acquired	Date	Comments
		Child crawls over to the wall while carrying spoon between teeth without dropping spoon.			
Walking: The ability to walk erect in a co-ordinated fashion without support.	With head up and shoulders back, child walks a specified path and walking line. Child can walk backward and sideways without difficulty. Needs practice in swing arms correctly, etc.	Walk forward in a straight line putting one foot directly in front of the other. Touch the heel of one foot to the toes of the other.			
		Walk backward in the same way, holding arms out. Be sure heels and toes are touching.			
Throwing: The ability to throw a ball with a reasonable degree of accuracy.	Child throws a ball to another person so that it may be caught, can throw ball accurately into box or basket. Bean bags, roll ball with accuracy, catching, etc.	Throw texture ball to teacher. Start with large ball.			
		Throw three balls into the wastebasket. (Distance approximately 4 ft.)			
		Play catch with this large ball (gradually reduce size of ball.)			

BASIC TASKS

Area of Deficit	Task (Demonstrate)	Instruction	Skill Acquired	Date	Comments
Jumping: The ability to jump simple obstacles without falling.	Child can jump from chair to floor without difficulty. Can jump from jumping board without falling. Can jump over knee-high obstacles. Start at child's level.	Jump back and forth over this line three times.			
		Jump rope forward.			
		Jump rope backward.			
Dancing: The ability to co-ordinate body in response to music.	In young children abilities are shown by free movement and rhythmic expression. Responds to music - build on this interest.	March in a circle and slap sides as teacher claps hands. Expand on this.			
		Dance freely to the record.			
		Play record with instruction and help child to respond.			
Self-identification: the ability to identify one's self.	Child can identify self by name, respond to name when called, and identify self in pictures and mirrors. Responds when name is called.	What is your name?			
		Point to yourself in this mirror. (Hand mirror should reflect part of the examiner and part of the child.)			
		Touch your eyes, nose, mouth, feet, and wrists			

BASIC TASKS

Area of Deficit	Task (Demonstrate)	Instruction	Skill Acquired	Date	Comments
Body localization: the ability to locate parts of one's body.	Child can locate eyes, hands, mouth hair, nose, feet, eyebrows, finger nails, shoulders, elbows, knees, back, neck, chin, forehead, wrists, arms, legs, toes.	Look in this mirror and point to your hair, teeth, eyebrows, and chin. What are your eyes for? What are your hands for? What is your stomach for? (Answers may have to be taught.)			
Body Abstraction: the ability to transfer and generalize self-concepts and body localization.	Child can identify others by names and pictures, can locate body parts on others, generalize to pictures, complete body picture puzzles.	Point to the clown's nose, hands, feet, knees, hair, and elbows			
Muscular Strength: The ability to use one's muscles to perform physical task.	Child can touch floor from standing position. From supine position he can sit up and touch toes, can raise legs off floor for	Draw a picture of yourself in this space. Draw your whole body; eyes, mouth, etc. Teacher may have to do drawing with instruction by child to start.			

BASIC TASKS

Area of Deficit	Task (Demonstrate)	Instruction	Skill Acquired	Date	Comments
	few second. Lift objects.	Crouch down like this (demonstrate) and when I say "go" jump up and reach over your head. Child may be physically helped. (May have to start with simpler task).			
		Stand up with your feet together and raise your hands over your head. Now bend over and touch the floor.			
		Do one or two push-ups.			
Sensory-motor integration: The psychophysical integration of fine and gross motor activities.					
Balance and Rhythm: The ability to maintain gross and fine motor balance and to move rhythmically.	Child is able to balance on balance board or rail, can move rhythmically in playing jacks and in bouncing on trampoline or spring.	Stand on your tiptoes and run in a circle.			
		Walk forward and then backward along this line (or balance beam task analysis).			
		Balance yourself on one foot while standing on a block, etc. Graduate to balancing.			

BASIC TASKS

Area of Deficit	Task (Demonstrate)	Instruction	Skill Acquired	Date	Comments
Body-spatial Organization: The ability to move one's body in an integrated way around and through objects in the spatial environment.	Child can run maze on playground or in classroom without bumping, can move easily through tunnels and use playground monkey bars, can imitate body positions in space	Begin with simpler task Climb up on chair and squat.			
		Crawl through teacher's legs without touching.			
		Stand up and help child to move arms and legs as shown.			
Tactile Discrimination: The ability to identify and match objects by touching and feeling.	With hidden toys and materials, child can match objects with both left and right hands, name or classify materials or substances, differentiate weights, discriminate temperatures. (Start with very basic task and proceed).	May have to begin with using vision and touch. Put your hand in the bag and give me the nail. (Bag contains nail, stick and pencil.)			
		Put your hand in the bag and give me the longest stick. (Bag contains 2" long, 4" long and 6" long sticks).			

BASIC TASKS

Area of Deficit	Task (Demonstrate)	Instruction	Skill Acquired	Date	Comments
Directionality: The ability to know up from down, forward from backward, and directional orientation.	Child can follow picture story or reading material from left to right. Locate directions in room and school. This will be very difficult. Break down and simplify.	Touch the floor with one hand, now the other. Shake your foot now the other one.			
		Put your finger on the bottom of this block. Now put your finger on the side of the block. Now the top.(Use square wood building block.)			
		Help him to understand that there are different sides to himself, a leaf, the room, etc.			
Perceptual-Motor Skills: The functional utilization of primary auditory, visual and visual-motor skills.					
Auditory Acuity: The ability to receive and differentiate auditory stimuli.	Child responds functionally to watch tick, hidden sound toys, and general normal conversational directions. Child has no significant decibel loss.	Hide watch under paper at different distances until he can no longer locate it.			
		Locate hidden music box			
		Try to get him to imitate tapping done out of his line of vision.			

BASIC TASKS

Area of Deficit	Task (Demonstrate)	Instruction	Skill Acquired	Date	Comments
Auditory Decoding: The ability to understand sounds or spoken words.	Child can follow simple verbal instructions, can indicate by gesture or words the meaning or purpose of auditory stimuli such as animal sounds, nouns, or verbs. Start with one phase directions, progress to 3. Keep simple, e.g. bring me the ball. Get the ball and throw it. Get the ball, put it on the floor, kick it to me.	Point to the appropriate picture as I make the sound: "meow", "choo-choo", "moo".			
		Answer "Yes" or "No": Nod yes or no - simplify if necessary. Do cars move? Is Billy a girl? Can a tree grow?			
Auditory Memory: The ability to retain and recall general auditory information.	Child can recite common nursery rhymes ("Jack and and Jill"), can verbally relate yesterday's experiences, meals etc. This will need much practice (Simplify)	What is your favourite song? Book?			
		Tell me the sound a snake makes; a train makes; a sheep makes.			
		Who brought you to school today?			

BASIC TASKS

Area of Deficit	Task (Demonstrate)	Instruction	Skill Acquired	Date	Comments
Auditory Sequencing: The ability to recall in correct sequence and detail.	Child can imitate specific sound patterns, follow exactly a series of directions, repeat digit and letter series. Clapping drum beats, beads dropping into can, etc.	Listen carefully and do what I say: "Put this pencil on the floor, open the door, walk around the room, come back, and sit down." Start with first part, work up.			
		Listen and repeat these numbers: "2-3, 5-1-8, 2-6-1, 1-6			
		Listen carefully and repeat what I say, "I like to play with my friends."			
Visual Acuity: The ability to see and differentiate meaningfully and accurately objects in one's visual field.	Needs to learn to focus visually before proceeding. Sees without noticeable fatigue holds material at appropriate working distance.	Look at the book (use reinforcement).			
		Show me the ______. Have several items - proceed.			
		To pictures - look at the ______. Have him label or find new items			

BASIC TASKS

Area of Deficit	Task (Demonstrate)	Instruction	Skill Acquired	Date	Comments
Visual Co-ordination and pursuit: The ability to follow and track objects and symbols with co-ordinated eye movements.	With head steady, can move eyes to fixate on stable objects in varied places, pursue moving objects such as finger positions, follow picture and word stories left to right without jerky movements.	Help to hold head still and move eyes - look at door, ceiling, floor.			
		Sit in front of child with a thumbtack in the eraser of a pencil; hold the pencil about 18 inches from the midline of child's nose. Have him follow the thumbtack with eyes as it moves to the left while counting to 5. Now follow it to the right while counting to 5. Now follow it as it moves up and down while counting to 5.			
		Encourage him to follow left to right while you read a book. Arrange pictures in this manner also.			

BASIC TASKS

Area of Deficit	Task (Demonstrate)	Instruction	Skill Acquired	Date	Comments
Visual-Form Discrimination: The ability to differentiate visually the forms and symbols in one's environment.	Child can match identical pictures and symbols such as simple objects, shape, pictures, animals, letters, numbers and designs.	Find me the one like this (objects).			
		Find me the one like this (animals).			
		Find me the one like this (designs, pictures).			
Visual Figure-Ground Differentiation: The ability to perceive objects in foreground and background and to separate them meaningfully.	Child can differentiate picture of self and friends from group picture, differentiate objects in "front" and "back" part of pictures and mock-ups, differrentiate his name from among others on paper or chalkboard, perceive simple forms imbedded in others.	Look at this picture. Where is the , ? (Note if background or foreground figure). Where is the ?			
		Look at this picture. (four hidden pictures) Ask him to find hidden pictures. (very simple start)			
		Using large simple picture, cut in pieces starting with foreground figures, gradually pasting in background items.			
Visual Memory: The ability to recall	Child can match or verbally recalls	Put 3 items on table, label. Hide one - have			

BASIC TASKS

Area of Deficit	Task (Demonstrate)	Instruction	Skill Acquired	Date	Comments
accurately prior visual experiences.	objects removed or changed in the environment, can match briefly exposed symbols.	him guess. Proceed to hiding them for 20 sec. Then repeat.			
		Show tray of items. Cover - have him recall as many as possible after 10 seconds.			
Visual-Motor Memory: The ability to reproduce motorwise prior visual experiences.	Child can reconstruct designs and symbols following brief exposure, can reproduce letters, numbers, identify hidden materials, objects	Place items in a sequence, label, mix and have him arrange as you had them.			
		Make a pattern with blocks - have him copy. Proceed to hiding pattern - removing patterns.			
Visual-Motor Fine Muscle Co-ordination: The ability to co-ordinate fine muscles such as those required in eye-hand tasks.	Child can imitate, trace, precise body movements without difficulty can cut, can manipulate, and can judge fine physical responses without gross errors. (Task analysis, backwards chaining).	Open box, close box.			
		Trace shapes.			
		Copy circle, etc.			

BASIC TASKS

Area of Deficit	Task (Demonstrate)	Instruction	Skill Acquired	Date	Comments
Visual-Motor Spatial-Form Manipulation: The ability to move in space and to manipulate three dimensional materials.	Child can build block houses and designs. Integrate form and space puzzles.	Look at this picture of a book on a table with a pencil and fix them like the picture.			
		Here is a picture of a paper airplane. You copy me, and we will make one together.			
Vocabulary: The ability to understand words.	Child has a basic receptive vocabulary.	Point to the house (woman, rocket, telephone).			
		Point to the helmet, (car, juggler, tiger).			
		Tell me the names of these objects. (Point to kangaroo, television motorcycle, telescope, stethescope).			

BASIC TASKS

Area of Deficit	Task (Demonstrate)	Instruction	Skill Acquired	Date	Comments
Fluency and Encoding: The ability to express oneself verbally.	Child can communicate verbally. Gestures need to be accepted, but should gradually be faded and replaced with language.	Encourage and reinforce use of language (and approximations).			
		Use objects to elicit labelling, phrases.			
		Encourage answering of "W" questions - may have to be methodically taught.			
CONCEPTUAL SKILLS: The functional level of concept attainment and general reasoning ability.					
Number concepts: The ability to count and use simple numbers to represent quantity.	Child can count and recognize concepts. Count to 5, gives 2, 3, etc. more, all.	Look at these pictures. Put your finger on the picture with the most ___________. Now put your finger on the picture with the least number of ________.			
		How many _______ are there? How many _____ are there?			
		Give me two blocks, count 5 blocks.			

BASIC TASKS

Area of Deficit	Task (Demonstrate)	Instruction	Skill Acquired	Date	Comments
Classification: The ability to recognize class identities.	Child can sort objects by classification. Needs to start with simple discrimination. All of a kind according to size/colour. All of a kind regardless of size/colour, all animals, etc.	Give me the red blocks. Give me the square blocks.			
		Sort sizes, shapes, colours.			
		Sort animals, furniture food, people, etc.			
Comprehension: The ability to use judgment and reasoning in common sense situations. Cause and effect.	Child responds to factual reasoning when situation is explained to him. Needs to start with cause and effect.	Place the dog in a house. Open the door - dog can get out.			
		Punch the key - the drawer opens.			
		Give me the apple - he gets apple. Proceed from there.			
SOCIAL SKILLS: The skills involved in social problem solving.					
Social Acceptance: The ability to get along with one's peers.	Child can relate meaningfully to others and is	Reinforce sharing, taking turns.			

BASIC TASKS

Area of Deficit	Task (Demonstrate)	Instruction	Skill Acquired	Date	Comments
	accepted in both one-to-one and group situations. Child needs one/one or small group situations and needs special situation to attract other children. If adult makes being with child fun, children will want to play.	Using food or other highly desirable item, make child the centre. (Tea party) Encourage parallel play or small group interaction.			
Anticipatory Response: The ability to anticipate the probable outcome of a social situation by logical inference.	Child can predict the consequences of his own behaviour and that of others in given situations. Cause and effect.	If child acts silly - he is ignored/stopped. When child initiates play, etc., he is rewarded. If he whines/cries he is ignored/stopped.			

Gen. #3

Original author unknown.

INDIVIDUAL CHILD PROFILE
OBSERVATIONAL DEVELOPMENTAL SURVEY
2 - 3 YEARS

INDIVIDUAL CHILD PROFILE
OBSERVATIONAL DEVELOPMENTAL SURVEY
(2-3 YEARS)

Child's Names ______________________ **Age** ______________________

Address ______________________ **Parents Name** ______________________

______________________ **Telephone** ______________________

Date(s) of Observation From ______________________ To ______________________

In developing a profile, please consider normal vs deviance behavior and the severity of the problem. Use "Y" for Yes, "N" for No - scale goes from 1 (least) to 5 (most severe).

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			A Physical Appearance				**Physical**
_	_	_	Healthy (good color - regular attendance).	_	_	_	Pale, flushed, dark circles, blue lips or hands.
_	_	_	Vigorous, Active.	_	_	_	Listless, apathetic, hyper, passive.
_	_	_	Even features, natural appearance.	_	_	_	Asymmetric features (wide spread eyes, large or small head, low or lack of earlobes).
_	_	_	Good use of arms, legs. Normal strength in arms, neck, torso. Good body build for age.	_	_	_	Rigidity in arms, legs. Flaccidity in arms legs, neck and torso. Distended abdomen, caved in chest, webbed fingers, neck anomalies.
_	_	_	Clear eyes, good eye contact.	_	_	_	Crossed eyes, reddened encrusted eyelids, tilting, turning head, rubbing eyes, limited eye contact. Poor scanning, vacant staring.

ICP Cont'd: **Name** ____________________

2-3 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			Appearance Cont'd:				
_	_	_	Responds to sounds, language (hearing).	_	_	_	Rarely responds, asks for repeats, inaccurate responses.
_	_	_	Good resistance to infection/disease intact central nervous system.	_	_	_	Susceptible to infection/disease/convulsive or seizure disorder/excessive enuresis /soiling.
_	_	_	Appropriate weight, height, body proportions for age.	_	_	_	Failure to thrive, weight below or above normal.
			Motor Developments				
_	_	_	Walks without falling.	_	_	_	Unusual gait (toes in, lurches, favors one side of body). Trips over own feet while walking, running. Frequent falling.
_	_	_	Walks up/down stairs holding rail both feet on step.	_	_	_	(May show fear of stairs/wants to be carried) crawls up steps, bumps down on bottom.
_	_	_	Rides wheeled toys by pushing self.	_	_	_	Shows no interest in moving wheeled toys.
_	_	_	Throws or kicks large ball.	_	_	_	Unable to release ball, cannot connect foot with ball.
_	_	_	Jumps in place two or more times.	_	_	_	Unable to raise both feet off floor simultaneous or to jump off step (two feet together).

ICP Cont'd:

Name ____________________

2-3 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			Motor Developments Cont'd:				
_	_	_	Strings beads.	_	_	_	Does not anticipate string coming through beads, clumsy fine motor, tremor.
_	_	_	Sits on heels or with legs forward.	_	_	_	Sits in CP squat.
			Self-Help				
_	_	_	Body autonomy (Beginning sphincter control).	_	_	_	Withholds, has no understanding of bodily functions, upset with toileting attempts (only of excessive).
_	_	_	Gets drink without help (some spilling).	_	_	_	Must be spoon fed - will eat only a few particular foods (obsessive).
_	_	_	Helps at household tasks.	_	_	_	Obsessed with cleaning, vacuuming or fearful of noise, movement.
_	_	_	Can partially undress.	_	_	_	Refuses or will wear only certain clothes, colors - becomes extremely upset if not available.
_	_	_	Begins to use fork.	_	_	_	Rejects eating with utensils - uses hands.
_	_	_	Occasionally attempts to put on some items of clothing.	_	_	_	Clothing must be put on in a certain way (ritualistic).
_	_	_	Can identify body parts.	_	_	_	Poor body awareness, unaware of place in space.

ICP Cont'd:

Name ____________________

2-3 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			B Cognition				**Cognition**
			General Knowledge				
_	_	_	Learning through exploration, manipulation, practicing mastery of simple puzzles, toys.	_	_	_	Explores through senses escessively mouths, smells, tastes.
_	_	_	Interested in simple cause and effect.	_	_	_	Rarely explores or shows curiosity, not attune to cause and effect, continually tests limits. Does not learn from experience.
_	_	_	Use of imagery, memory.	_	_	_	Inner imagery not developed - out of sight, out of mind.
_	_	_	Egocentric cognitive development (eg. knows mine from yours).	_	_	_	Completely egocentric - aware only of self.
_	_	_	Cannot take others point of view wants own way.	_	_	_	Withdrawn - avoids peers - immersed in own world.
_	_	_	Can carry out 2 simple directions.	_	_	_	Refuses or may only be capable of responding to one direction (with repeats, guidance).
_	_	_	Recognizes and names most common objects.	_	_	_	Has difficulty with recall, labels.
_	_	_	Can count to three but does not understand concepts.	_	_	_	Cannot count, shows no interest (or may one day, not the next.
_	_	_	Can use one object to represent another.	_	_	_	Has no representational ability - concrete.

ICP Cont'd:

Name________________________

2-3 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			General Knowledge Cont'd:				
_	_	_	Can do simple form board, pegs in pegboard (3-4).	_	_	_	Avoids toys requiring problem solving.
_	_	_	Pulls chair to counter to get object.	_	_	_	Unresponsive to environment.
_	_	_	Uses "No" rather than problem solve. Uses adults to meet needs if necessary.	_	_	_	Psudo-independent - avoids adults.
_	_	_	Is headstrong, often stubborn.	_	_	_	Becomes quickly frustrated, engages in temper tantrums (often excessive). Aggressive - cannot be comforted .
			Language				
_	_	_	"Why" age - asks where/what questions.	_	_	_	Expressive language poorly developed.
_	_	_	Recites portions of nursery rhymes or songs.	_	_	_	Seems unable to memorize even simple phrases.
_	_	_	Combines 2 to 3 words (2-3 word sentence) to express semantic relations.	_	_	_	Single words, grunts, gestures or avoids.
_	_	_	Uses and recognizes own name.	_	_	_	Does not respond to name or uses it excessively.
_	_	_	Uses personal pronouns - errors in syntax.	_	_	_	Uses pronouns inappropriately.
_	_	_	Vocabulary of 275-500 words.	_	_	_	Limited vocabulary (10-15 words).

ICP Cont'd:

2-3 Years

Name ____________________

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			Language Cont'd:				
_	_	_	Understands concept of "more, cold, tired, hungry".	_	_	_	No understanding of concepts, uses own jargon, gestures.
_	_	_	Demonstrates understanding of common verbs.	_	_	_	Unable to respond to action words - must demonstrate.
_	_	_	Understands size differences.	_	_	_	Totally confused with differences.
_	_	_	Recognizes picture by function.	_	_	_	Uses function rather than label.
_	_	_	Understands simple relationships.	_	_	_	Becomes overwhelmed with simple explanations.
			C Emotionality				**Emotional**
			General				
_	_	_	Imaginative.	_	_	_	Play is static, repetitive.
_	_	_	Difficulty with delaying gratification (can delay momentarily - slight frustration).	_	_	_	Difficult to appease/distract. Prolonged intense/numerous temper tantrums, irritability, crying, breath holding.
_	_	_	Developing sense of humor.	_	_	_	Laughs wildly, inappropriately.
_	_	_	Fears moving animals, unusual sounds, new or unfamiliar experience.	_	_	_	Intense diffuse fears, night terrors.

ICP Cont'd: Name ____________________

2-3 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			General Cont'd:				
_	_	_	Egocentric/self centered. Some awareness of others.	_	_	_	Poor sense of self/constantly seeks instant gratification.
_	_	_	Dependent (attempts at independence, ambivalence re dependence/independence).	_	_	_	Clings to adults/refuses help or psudo-independent. No sense of danger situations.
_	_	_	Needs to be active/move.	_	_	_	Hyperactive or hypoactive.
_	_	_	Adjusts to toilet training demands.	_	_	_	Fears of toileting - no concept of requirements or fascination with flushing.
_	_	_	Can gratify some of own needs.	_	_	_	Demanding - intrusive.
_	_	_	May have difficulty expressing own needs.	_	_	_	Non-communicative.
_	_	_	Fears punishment.	_	_	_	Cowers, expects to be "hit - does not learn from time out, positive or negative reinforcement.
_	_	_	Can express likes/dislikes. Desire to please parents/significant others. Self-contradictory reasoning.	_	_	_	Ritual bound mannerisms. Resigned behavior - no desire to please, depressed behavior.
_	_	_	Beginning "good boy/bad boy stage.	_	_	_	Everyone either good or bad - usually sees self or anyone who crosses him as bad.
_	_	_	Curious - explores with enjoyment and enthusiasm.	_	_	_	Lack of interest in environment or inappropriate exploration.

ICP Cont'd:

Name____________________

2-3 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			General Cont'd:				
_	_	_	Reminents of separation/individuation stage.	_	_	_	Symbiotic clinging (panic).
_	_	_	"No" stage - doesn't obey.	_	_	_	Difficulty with external demands - excessive upset or panic, withdrawal.
_	_	_	Outbursts of temper especially when thwarted.	_	_	_	Prolonged, intense or numerous temper tantrums, irritability, crying, breath holding.
_	_	_	Short attention span - active, restless, rebellious, resistant, impulsive, loud, inconsistent.	_	_	_	Stays long periods with one toy (withdrawn) or acts to the extreme.
_	_	_	tires easily.	_	_	_	Unable to stop, rest although exhausted.
_	_	_	"Now" dimension of time. Can usually be appeased or distracted.	_	_	_	Cannot be distracted - partial return to infantile behavior.
_	_	_	Copes adequately with stressful situation. Enjoys opposites.	_	_	_	Excessive negativism, timidity towards people and experience. Exhibits high degree of stress (bites nails, cries, sucks fingers, rigid postures).
_	_	_	Repetitive behavior (mastery).	_	_	_	Obsessive negativeness, possessiveness, repetitive behavior without purpose.
_	_	_	Self-contradictory and concrete reasoning.	_	_	_	Hostility/impulsive, destructive behavior.

ICP Cont'd:

Name ____________________

2-3 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			General Cont'd:				
_	_	_	Eager to learn and please. Wants sensory experience.	_	_	_	Indifferent/withdrawn. Obsessive - compulsive.
_	_	_	Capable of representional organization, thought, (imagery).	_	_	_	Disorganized emotional and motor responses, clinging.
_	_	_	Appropriate fearfulness, anxiety, demandingness and some clinging (temporary and intermittent, responds to support and empathy).	_	_	_	Primitive aggressive behavior. Chronic fearfulness, disruption of exploratory behavior usually causes panic or withdrawal.
_	_	_	Capable of pretend, imaginative play.	_	_	_	Regression, may speak nonsense syllables or words that have little connection to one another.
_	_	_	Capable of mental representations of internal and external objects (not necessarily well organized or having logical relationships).	_	_	_	Relates only to the inanimate world (will do puzzles, etc. but avoid peers/adults). Intrusive, disorganized or loose associations.
_	_	_	Magical thinking. Beginning to realize own true size in relation to his world.	_	_	_	Uses symbolic modes only around dominance, negativism and aggression (always "No" or "I want that") or in a passive, compliant and superficially pleasurable manner.
_	_	_	Joyous - in love with life.	_	_	_	Looks solemn, stubborn, angry. May vacillate between compliance (superficial pleasure) and TT's. Unable to express hearty laughter or joyous compliance.

ICP Cont'd:

Name ____________________

2-3 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			General Cont'd:				
_	_	_	Capable of meaningful relationships.	_	_	_	Shallow personality which has an unreal quality. Avoidance.
_	_	_	May dream (trains, pigs under bed), usually wakes up pleasantly.	_	_	_	Numerous and severe night terrors - rarely sleeps in own bed.
_	_	_	Interested in physical differences between sexes. (positions of boys/girls urinating.)	_	_	_	Shows no interest in sex differences/overly interested. Denies or does not know own sex.
			Temperament/Self Esteem				
_	_	_	Outbursts of temper, especially when thwarted.	_	_	_	Excessive anger/aggression/loss of control, hits, bites, runs or has full-blown T.T. Unresponsive, undefended.
_	_	_	Excited or upset when opposed to situation. Can express wonder. Secure and pleased with self.	_	_	_	Unaware, disinterested in surrounding - obsessed with particular items.
_	_	_	Appropriate expressions of anger/control.	_	_	_	Unpredictable, lack of control.
_	_	_	Autonomy, without excessive shame/guilt.	_	_	_	Withdrawn, indifferent, no apparent guilt or conscious. Sees self to blame (excessive). Sees self as worthless.
_	_	_	Pride in clothes. Enthusiastic (love of life).	_	_	_	Lethargic, shows no happiness, joy.

ICP Cont'd: **Name** ______________________

2-3 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			Temperament/Self Esteem Cont'd:				
_	_	_	Trust vs. mistrust. Mood usually positive. Aware of own motives, beginnings of conscience.	_	_	_	Fearful, unable to develop relationships or is superficially and overly friendly to anyone. Lack of discrimination. Acts randomly, often irrationally or in a bizarre manner.
_	_	_	Secure (feels supported and sure of parents approval and love).	_	_	_	Insecure, cannot separate or rushes in where "fools would fear to tread".
_	_	_	Feelings of omnipotence/confidence.	_	_	_	Fearful, unhappy, doesn't play.
_	_	_	Only traces of fear of object loss (loss of love).	_	_	_	Extreme fear of object loss. Lack of interest in peers/adults.
_	_	_	Seeks interaction.	_	_	_	Withdraws/isolated.
_	_	_	Individuation in process or satisfactorily in place (approval and love).	_	_	_	Does not recognize love objects (mother/here father) as separate individuals.
_	_	_	Well on way to libidinal object constancy.	_	_	_	Extreme separation anxiety (panic/clinging/extreme upset). No concept of object constancy.
_	_	_	Can make reasonable choices.	_	_	_	Clings to one object, unable to make choices - upset.

Name ____________________

ICP Cont'd:

2-3 Years

Y N # **NORMAL DEVELOPMENT**

D **Socialization**

_ _ _ Solitary/Parallel Play.
Interactive games with adults.
Can initiate own play activities.

_ _ _ Brings favorite toy but doesn't want to show or share.

_ _ _ Has more disputes with peers than at any other age.

_ _ _ Can't wait or share.

_ _ _ Sudden aggressive attacks - may hit stranger.

_ _ _ Sibling jealousy.

_ _ _ Likes to visit relatives.

_ _ _ Engage in doll play (symbolic play).

Y N # **DEVIANCES**

Socialization

_ _ _ Engages exclusively in isolated, solitary play, unhappy, depressed, clinging.

_ _ _ Unable to move freely, or make choices.

_ _ _ Becomes panicked when approached by peers.

_ _ _ Primitive, aggressive or withdrawal - no defense.

_ _ _ Does not expect recognition. Plays on the periphery, sudden panic, flight.

_ _ _ Ignores (appears unaware even in their midst) peers.

_ _ _ Seclusive (refuses to leave own home).

_ _ _ No symbolic or imaginative play.

INDIVIDUAL CHILD PROFILE
OBSERVATIONAL DEVELOPMENTAL SURVEY
3 - 4 YEARS

INDIVIDUAL CHILD PROFILE
OBSERVATIONAL DEVELOPMENTAL SURVEY
(3-4 YEARS)

Child's Names ______________________ **Age** ______________________

Address ______________________ **Parents Name** ______________________

______________________ **Telephone** ______________________

Date(s) of Observation From ______________________ To ______________________

In developing a profile, please consider normal vs deviance behavior and the severity of the problem. Use "Y" for Yes, "N" for No - scale goes from 1 (least) to 5 (most severe).

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			A Physical Appearance				**Physical**
_	_	_	Healthy (good color - regular attendance).	_	_	_	Pale, flushed, dark circles, blue lips or hands.
_	_	_	Vigorous, active.	_	_	_	Listless, apathetic, hyper, passive.
_	_	_	Even features, natural appearance.	_	_	_	Asymmetric features (wide spread eyes, large or small head, low or lack of earlobes).
_	_	_	Good use of arms, legs. Normal strength in arms, neck, torso. Good body build for age.	_	_	_	Rigidity in arms, legs. Flaccidity in arms legs, neck and torso. Distended abdomen, caved in chest, webbed fingers, neck anomalies.

ICP Cont'd:

3-4 Years

Name ____________________

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			Appearance Cont'd:				
_	_	_	Clear eyes, good eye contact.	_	_	_	Crossed eyes, reddened encrusted eyelids, tilting, turning head, rubbing eyes, limited eye contact. Poor scanning, vacant staring.
_	_	_	Responds to sounds, language (hearing).	_	_	_	Rarely responds, asks for repeats, inaccurate responses.
_	_	_	Good resistance to infection/disease, intact central nervous system.	_	_	_	Susceptible to infection/disease/convulsive or seizure disorder/excessive enuresis /soiling.
_	_	_	Appropriate weight, height, body proportions for age.	_	_	_	Failure to thrive, weight below or above normal.
			Motor Developments				
_	_	_	Can walk, run on tiptoe.	_	_	_	Constant running (hyperkinetic) clumsy.
_	_	_	Pedals tricycle.	_	_	_	Pushes with feet, poorly coordinated.
_	_	_	Alternates feet on stairs.	_	_	_	Wants to be carried up/down stairs or crawls.
_	_	_	Balances and hops on one foot.	_	_	_	Cannot hop on one foot.
_	_	_	Jumps lifting both feet off ground. Throws ball with direction.	_	_	_	Cannot jump lifting both feet off floor together or throw ball.
_	_	_	Swings on swing independently.	_	_	_	Fearful of swings, slides.

ICP Cont'd:

Name ____________________

3-4 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			Motor Developments Cont'd:				
_	_	_	Correct hand grasp on crayon, large pencil.	_	_	_	Refuses (or cannot use) crayons, pencils.
_	_	_	At scribbling stage in drawing (beginning some form).	_	_	_	Scribbles indiscriminately.
_	_	_	Can manipulate small objects.	_	_	_	Avoids small manipulative toys, may have tremor or be poorly coordinated.
			Self-Help				
_	_	_	Exercise autonomy over body functions (may not have complete control).	_	_	_	Fears, panic, refusals re toileting. Does not have sphincter control.
_	_	_	Can feed self, uses fork.	_	_	_	Insists on being spoon feed or uses fingers.
_	_	_	Brushes teeth with help. Hangs up coat with instructions. Cleans up spills with help.	_	_	_	Primitive eating habits. Unaware of spills, need to clean up.
_	_	_	Blows nose when reminded. Beginning of dressing/undressing. Hangs coat with instruction.	_	_	_	Unaware (or refusal) of need to help with dressing/undressing, unable to learn concept.
_	_	_	Can serve self with help or instruction.	_	_	_	Uncoordinated at serving self but cannot listen to instructions or wait turn - intrusive.

ICP Cont'd: Name ______________________

3-4 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			B Cognition				**Cognition**
			General Knowledge				
_	_	_	Listens and understands short story (5 minutes).	_	_	_	Restless, unable to settle or maybe obsessed with book. Spends abnormal amount of time alone with books.
_	_	_	Can repeat 3-4 digits - understands concept of 2.	_	_	_	May be able to count - no concept formation.
_	_	_	Follows 3 related directions, understands taking turns.	_	_	_	Ignores requests - becomes upset, temper tantrum if pressed.
_	_	_	Reality testing.	_	_	_	Confusion of internal-external subjective-objective.
_	_	_	Identity established, beginning to draw a person - features adequately in place.	_	_	_	Disoriented in space, time and identity.
_	_	_	Symbolism and imagery well established (complex planning and manipulation of "thoughts" eg., elaborate role play).	_	_	_	Inability to form mental representations - uses disorganized emotional, motor, primitive aggressive behavior (biting, scratching, throwing things, fearfulness, withdrawal or regression).
_	_	_	Continues to learn through exploration, manipulation and mastery.	_	_	_	Engages in non-symbolic non-exploratory activities, such as rolling a ball or car back and forth, aimlessly throwing toys on floor, wandering around or looking for infantile interactions (not requiring symbolic activity) such as peek-a-boo.

ICP Cont'd: **Name** ______________________________

3-4 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			General Knowledge Cont'd:				
_	_	_	Is capable of matching and sorting simple objects, colors, can discriminate, label, recall objects, people. Beginning of constructive, co-operative play.	_	_	_	Exhibits poor scanning or becomes caught in small details vs "the whole". Has difficulty with recall, gives associative or functional answers.
_	_	_	Building materials used for construction and destruction.	_	_	_	Avoids creative materials, may be confused re their use.
_	_	_	Recognizes concepts big/little; heavy/light; long/short.	_	_	_	Poor discrimination, cannot match or sort (may not know colors, objects consistently).
_	_	_	Is egocentric - unable to take another's point of view. Categorical judgments - right vs wrong, good vs bad.	_	_	_	Seemingly unaware of others around him. No self identity.
_	_	_	Completes 6-8 piece puzzle using problem solving strategies.	_	_	_	Uses trial and error - may fail to complete simple puzzles/peg boards or maybe a "wizz" at concrete tasks avoiding all others.
_	_	_	Awareness of consequences of own actions. Limited understanding of intentionality. Searches for ways to activate or use a toy.	_	_	_	No awareness of cause and effect. Limited curiosity or a tendency to take everything apart.

ICP Cont'd:

3-4 Years

Name ____________________

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			Language				
_	_	_	Tells full name when requested. Uses pronouns, past tense, plurals (usually correctly).	_	_	_	Little or no speech/articulation faulty. Unintelligible - uses grunts, gestures. Remains silent. Does not appear to know own name or uses it inappropriately. May or may not talk in solitary play.
_	_	_	Answers simple "how" questions.	_	_	_	Will not or cannot answer questions. Reversal of pronouns, no plurals, past tense.
_	_	_	Changes word order appropriately to ask question. Tells two event sequentially. Four-five word sentences. Names most objects and pictures. Asks many questions. Knows concept of animals, toys, food, beside, behind, in front.	_	_	_	Single or 2 word phrases.
_	_	_	Repeats simple nursery rhymes, songs.	_	_	_	Cannot repeat nursery rhymes but may be able to sing or chant them.
_	_	_	Vocabulary of 500 words. Uses language to mediate.	_	_	_	Engages in echolalia, repetitive or delayed imitative speech, uses "clang" or nonsense words.

ICP Cont'd: **Name**____________________

3-4 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			C Emotionality				**Emotional**
			General				
_	_	_	Desire to please parents and significant others.	_	_	_	Turned inward - responds to internal needs/wants only.
_	_	_	Learning about sex roles (and sexual identity).	_	_	_	Denial or unaware of sex identity - longs to be of opposite sex - cross dresses.
_	_	_	Possessiveness. Developing sense of right/wrong without overwhelming guilt.	_	_	_	May experience overwhelming guilt or the very opposite (no conscience).
_	_	_	Cautious in new situations.	_	_	_	Rushes into a new situation with no sense of caution or danger. Excessive reluctance/upset in new situations.
_	_	_	Developing sense of cause and effect at a higher level (eg. "I did so and so and you got mad at me").	_	_	_	Cause and effect reasoning capabilities not developed (no sense of "I did this to cause this"). Is confused about who did what.
_	_	_	Separates animate from inanimate, past from present, self from non-self, (internal representational experiences, imagery becoming more organized).	_	_	_	Projects own aggressive feelings causing chronic apprehension and fear - sees the world as dangerous - may withdraw.
_	_	_	Values people for own worth. Establishes defense mechanisms.	_	_	_	May be impulsive and disrespectful - aggressive, defenseless and vulnerable.

ICP Cont'd:

3-4 Years

Name________________________

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			General Cont'd:				
_	_	_	Beginning of superego development. Strives for goals and for power. Regulates impulses, sense of self established.	_	_	_	Chaotic behavior patterns, weak ego, regresses to autistic patterns where relatedness to the inanimate world replaces the animate world. Cannot control impulses, severe regression.
_	_	_	Beginning to take responsibility for own actions.	_	_	_	Uses projection, paranoid distortion, cannot control or regulate impulses, inappropriate reaction (eg. slaps own hand or giggles after breaking a dish).
_	_	_	Self-intention in terms of short-term future planning.	_	_	_	Inner representational imagery not developed - cannot place ahead.
_	_	_	Able to focus and concentrate. More stable in the face of stress.	_	_	_	Seems driven, unable to focus or concentrate. Appears to lose contact with reality. Can become overwrought, overwhelmed or enraged.
_	_	_	Can follow simple rules and regulations.	_	_	_	No sense of rules or regulations or conversely obsessive about them.
_	_	_	Greater integration between what they say and what they feel (integration of thought and affect).	_	_	_	Unable to recognize or express own feelings.
_	_	_	Beginning of interactive teasing.	_	_	_	Concrete - cannot recognize humor, teasing. Constantly testing.

ICP Cont'd:

Name ____________________

3-4 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			Temperament/Self Esteem				
_	_	_	Moods become more stable.	_	_	_	Extreme mood swings from day to day (or even within a short period of time).
_	_	_	Some recognition of moods, needs and tensions of others.	_	_	_	Is unable to "read" non-language cues - no awareness of anger etc., in others.
_	_	_	Friendly in response to peers/adults.	_	_	_	Hostile, angry, avoidant.
_	_	_	Can reasonably delay gratification.	_	_	_	Little self control in waiting or high degree of self-control.
_	_	_	Play includes periods of both peer and solitary play.	_	_	_	Prefers solitary play or becomes intrusive.
_	_	_	Positive sense of personal worth through success, creativity, achievement, belonging, cooperation, curiosity and enthusiasm.	_	_	_	Poor self esteem - displays behaviors of aggression, indifference, failure, withdrawal, fear, tension and/or submissiveness.
			D Socialization				**Socialization**
_	_	_	Beginning of co-operative play.	_	_	_	Solitary/parallel play (may not be able to play).
_	_	_	Sense of belonging.	_	_	_	Has not developed sense of trust.

INDIVIDUAL CHILD PROFILE
OBSERVATIONAL DEVELOPMENTAL SURVEY
4 - 5 YEARS

INDIVIDUAL CHILD PROFILE
OBSERVATIONAL DEVELOPMENTAL SURVEY
(4-5 YEARS)

Child's Names ______________________ **Age** ______________________

Address ______________________ **Parents Name** ______________________

______________________ **Telephone** ______________________

Date(s) of Observation From ______________________ To ______________________

In developing a profile, please consider normal vs deviance behavior and the severity of the problem. Use "Y" for Yes, "N" for No - scale goes from 1 (least) to 5 (most severe).

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			A Physical				**Physical**
			Appearance				
_	_	_	Healthy (good color - regular attendance).	_	_	_	Pale, flushed, dark circles, blue lips or hands.
_	_	_	Vigorous, active.	_	_	_	Listless, apathetic, hyper, passive.
_	_	_	Even features, natural appearance.	_	_	_	Asymmetric features (wide spread eyes, large or small head, low or lack of earlobes).
_	_	_	Good use of arms, legs. Normal strength in arms, neck, torso. Good body build for age.	_	_	_	Rigidity in arms, legs. Flaccidity in arms legs, neck and torso. Distended abdomen, caved in chest, webbed fingers, neck anomalies.

ICP Cont'd:

Name ____________________

4-5 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			Appearance Cont'd:				
_	_	_	Clear eyes, good eye contact.	_	_	_	Crossed eyes, reddened encrusted eyelids, tilting, turning head, rubbing eyes, limited eye contact. Poor scanning, vacant staring.
_	_	_	Responds to sounds, language (hearing).	_	_	_	Rarely responds, asks for repeats, inaccurate responses.
_	_	_	Good resistance to infection/disease, intact central nervous system.	_	_	_	Susceptible to infection/disease/convulsive or seizure disorder/excessive enuresis /soiling.
_	_	_	Appropriate weight, height, body proportions for age.	_	_	_	Failure to thrive, weight below or above normal.
			Motor Developments				
_	_	_	Vigorous, dynamic.	_	_	_	Lethargic, disinterested.
_	_	_	Builds, drives, pilots. Accurate body movements.	_	_	_	Poor motor control -plays obsessively with certain toys.
_	_	_	Acrobatic.	_	_	_	Hyperkinetic, clumsy.
_	_	_	Can jump own height, land upright.	_	_	_	Can't jump with two feet at once (possible neurological implications).
_	_	_	Throws ball, kick with some accuracy.	_	_	_	Can't release ball or connect with foot.

ICP Cont'd: **Name** ______________________________

4-5 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			Motor Developments Cont'd:				
			Dresses self except for some closings (may not always want to do so).				Refuses to dress, self-upset, dawdles, has difficulty manipulating clothing.
			Can't set limits - active until exhausted.				Withdrawn, fearful. Maybe either hypo or hyperkinetic.
			Self-Help				
			Cleans up spills without help.				Unaware that it is "his" spill. Upset, expects to be severely punished - cowers away.
			Washes face and hands without help.				Needs to be reminded to wash - has to have adult's help.
			Bladder control at night.				Uses diapers at night - no protest.
			Uses knife for cutting.				Wants to be fed - uses fingers or spoon.
			Brushes teeth without help.				Wants to have adults help - refuses.
			Puts on shoes and boots without help.				Beginning to take of shoes/boots expects to have adults help. Poor coordination, strength.
			Independent with toileting.				May still be in diapers. Needs reminders, help. Fear or fascination with toilet.

ICP Cont'd: **4-5 Years** **Name** ____________________

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			B Cognition				**Cognition**
			General Knowledge				
_	_	_	Can draw 6 part person.	_	_	_	Poor spatial orientation (eyes, nose, etc., outside of head).
_	_	_	Knows colors.	_	_	_	May know colors one day, not the next.
_	_	_	Knows most concepts.	_	_	_	Knows only simple concepts - in, on, up.
_	_	_	Can carry out a four part direction.	_	_	_	May be able to do two part direction with help.
_	_	_	Likes variety of materials.	_	_	_	Avoids creative materials.
_	_	_	Accepts change with preparation.	_	_	_	Is unable to use prior preparation, becomes obsessive/upset.
_	_	_	Fabricates - confuses fact and fantasy, aware of natural world (life, death, birth, science). Some confusion, may recognize immobility of the dead - sees himself as always living.	_	_	_	Often confused -does not understand the issue/situation. Avoidance/fear.
_	_	_	Produces recognizable forms - constructions. Takes pleasure in finished product.	_	_	_	Drawings still at formless stage - simply using colors to cover page.
_	_	_	Slap-dash experimentation. Dynamic intellectual drive.	_	_	_	No organized interest or drive. May be depressed.

ICP Cont'd: **Name**____________________

4-5 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			General Knowledge Cont'd:				
_	_	_	Can do two things at once. Attention span of 8-12 minutes.	_	_	_	Poor concentration. Can only content with one modality at a time. Flits from activity to another or stays overly long at low-level activities.
_	_	_	Argumentative. Enjoys silly words, rhymes	_	_	_	May imitate bathroom swear word without recognition or any awareness of their inappropriateness, may become obsessed and seem unable to "move on".
_	_	_	Able to talk to resolve conflict.	_	_	_	Loses language ability in times of conflict - reverts to premature or primitive behaviors.
_	_	_	Self directed. Good at problem solving. Greater impulse control, uses materials positively and constructively. Competitive, well organized, takes pleasure in ultimate outcome.	_	_	_	Poor impulse control. Little interest in end result.
_	_	_	Cognitive advances in thinking, but still egocentric. Ambivalence over dependency, separation, and new experiences.	_	_	_	Primary process thinking. Separation anxiety/clings to parent.
_	_	_	Shows ability to stay on task.	_	_	_	Extremely distractable, unable to focus.
_	_	_	Uses reason to solve problems.	_	_	_	Relies on trial and error to solve problems.

ICP Cont'd:

Name ____________________

4-5 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			General Knowledge Cont'd:				
_	_	_	Uses cause and effect relationships to solve more complex problems.	_	_	_	At very basic understanding re cause and effect (turn knob-door opens). Cannot extend to solve complex problems.
_	_	_	Can generate and extend new ideas.	_	_	_	Unable to generate or respond to new ideas - clings to the familiar.
_	_	_	Verbalizes problems.	_	_	_	Limited ability to understand problem or verbalize need.
			Language				
_	_	_	Sophisticated use of language (loves to talk).	_	_	_	Persistent speech problems (poor recall, stammering, poor articulation repetition).
_	_	_	Uses language to mediate and maintain psychic equilibrium.	_	_	_	Inability to follow verbal instruction (poor comprehension, poor auditory memory.
_	_	_	Relates experiences with sequential and coherent content.	_	_	_	Poor auditory sequencing (cannot put what he hears in proper order).
_	_	_	Vocabulary of 1500 words, uses future, past tense.	_	_	_	Limited vocabulary 50-100 words. Poor auditory association (cannot orally associate concepts such as opposite words).
_	_	_	Enjoys silly word, rhymes.	_	_	_	Maybe obsessed with silly, nonsense or "clang" words. Poor auditory or visual discrimination, poor comprehension.

ICP Cont'd:

Name ____________________

4-5 Years

Y	N	#	**NORMAL DEVELOPMENT**	Y	N	#	**DEVIANCES**
			Language Cont'd:				
_	_	_	Recognizes same/different. Responds to questions involving time ("when are you going to bed?"). Defines words in terms of use.	_	_	_	Lag in expressive/receptive language. Unable to understand concepts.
_	_	_	Problems solved through representation, language.	_	_	_	Poor imagery, word recall problems (cannot remember specific words although he knows them).
_	_	_	Recognizes general categories (animals, fruit, people, etc.). Watches and enjoys appropriate TV programs.	_	_	_	Does not understand categorization, can't attend, becomes obsessed with commercials using them in delayed echolalia.
_	_	_	Counts to 20.	_	_	_	Counts to 5-10.
_	_	_	Tells age and sex.	_	_	_	Cannot relate age or sex (maybe due to poor auditory memory, sequencing, poor gender identity).
_	_	_	Uses "I, me, you, he and him" properly.	_	_	_	Refers to self by name, poor use of pronouns, confusion and reversals.
			C Emotionality				**Emotional**
			General				
_	_	_	Symbolic interactive play.	_	_	_	Representational symbolic imagery appears to be lacking or poorly established.

ICP Cont'd:

4-5 Years

Name ____________________

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			General Cont'd:				
_	_	_	Initiative vs guilt.	_	_	_	No display of initiative - can be overwhelmed with guilt or appear to have no conscience.
_	_	_	Regulates emotions.	_	_	_	Has difficulty with regulation of emotions - undisciplined, incorrigible, impulsive.
_	_	_	Shows ability to focus mentally (no signs of stress/fatigue).	_	_	_	Has difficulty with focus. Many indicators of stress or fatigue e.g. bullies peers, destroys property, responds irritably, regresses to wetting, infantile pronunciation, drinking from bottle, rigid posture, whining tone, strained expression, hitting, biting.
_	_	_	Usually separates will (may need a few minutes).	_	_	_	Reaction to separation may result in frequent crying, sensitivity to criticism, extensive worry, listlessness.
_	_	_	Displays well adjusted emotional balance.	_	_	_	Extremely withdrawn, distorted interpersonal relations, bizarre or meaningless play/language, unusual motor behaviors.
_	_	_	Uses language instead of physical assault to settle quarrels (increased self control).	_	_	_	Regresses to primitive aggressive behavior, screaming, panic, temper tantrums.

ICP Cont'd: **Name** ____________________

4-5 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			General Cont'd:				
_	_	_	Well developed sense of trust, secure feelings that basic needs will be met.	_	_	_	Sense of trust not developed - fearful of adults and peers - insecure and feels he must meet own needs - feels the victim, vulnerable and fragile.
_	_	_	At the stage of "finding out about himself and the kind of person he will be" - a stage initiative often involving aggressive behavior that is usually unintentional.	_	_	_	Will not risk exploring re self, defends with aggression, withdrawal (*this of aggression stems from a very different source than that of the normal child).
_	_	_	Role playing to try out adult standards of right/wrong - may provoke feeling of guilt.	_	_	_	Limited role playing. Can readily be overwhelmed with guilt lose any initiative and confidence he may have had.
_	_	_	Tendency to blame peers for things he does fully understand.	_	_	_	Uses excessive blame, projection as a not defence for many feelings, situations.
_	_	_	Easily over stimulated, resistant, test limits, uses alibies frequently.	_	_	_	Low frustration, rigid-stereotyped, preservative, repetitious, compulsive stimulus- bound, inhibited.
_	_	_	Explosive, destructive on occasion.	_	_	_	Inadequate coping, sense of helplessness, chaotic, aimless, disorderly.
_	_	_	Identifies with strength - behavior goal directed (identifies with aggressor).	_	_	_	Aimless play - obsessed with power play.

ICP Cont'd:

Name____________________

4-5 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			General Cont'd:				
_	_	_	Make believe without becoming overly fearful or anxious.	_	_	_	Projects own aggressive feelings, sees the world as dangerous, is chronically apprehensive, may tend to withdraw.
_	_	_	Establishment of representational differentiation and basic ego functions (shift from fantasy to reality).	_	_	_	Shift from fantasy to reality not taking place resulting in distortions in reality - oriented thinking,negative withdrawal. Attempt to avoid difficult situations - becomes passive, compliant, superficially affectionate.
_	_	_	Copes with some teasing, displays sense of humor, nonsense-loving, silly.	_	_	_	Prone to depression.
			Temperament/Self Esteem				
_	_	_	Integrating thought and affect (basic ego function).	_	_	_	Fragile ego - limited integration of though and affect (may laugh when a child gets hurt).
_	_	_	Moods become more stable, usually positive attitude.	_	_	_	Euphoria, clowning, laughing or sadness, grief, depression, despair.
_	_	_	Feelings of personal worth characterized by feelings of acceptance, security, love, encouragement and understanding.	_	_	_	Sense of helplessness, worthlessness, sense of failure - feelings of rejection, anger - distrust, impatience, guilt and discouragement. Poor response or relationship to people, symbiotic clinging to mother.

ICP Cont'd:

4-5 Years

Name ______________________

Y	N	#	**NORMAL DEVELOPMENT**	Y	N	#	**DEVIANCES**
			Temperament/Self Esteem Cont'd:				
_	_	_	Shows off, cocky, noisy, loves to tease, outwit.	_	_	_	Timidity towards people and experiences. Lacks caution, non-discriminative.
_	_	_	Covers up unsureness with swagger and bravado.	_	_	_	Somatic ills; vomiting, constipation, rashes tics.
_	_	_	Insists on what he wants.	_	_	_	Uses infantile behavior "ritual" bound mannerisms. Impulsive destructive behavior.
_	_	_	Demonstrates pride and self confidence.	_	_	_	Little sense of self.
			D Socialization				**Socialization**
_	_	_	Co-operative interaction with peers.	_	_	_	Parallel or association play.
_	_	_	Dominant - bossy, boastful.	_	_	_	Hostile, controlling, angry, dependent, clinging.
_	_	_	Enjoys peer play - is receptive and enthusiastic.	_	_	_	Avoids social situations, anxious, withdrawn, fearful.
_	_	_	Is independent, takes turns and shares toys (usually).	_	_	_	Cannot join group or take turns without help. Intrusive, unaware.
_	_	_	Protects younger children and siblings.	_	_	_	Often hurtful to younger children. Shows no awareness of the need to be nurturing.
_	_	_	Can play in groups of two to five.	_	_	_	Shuns groups of children.

ICP Cont'd:

Name ______________________________

4-5 Years

Y	N	#	NORMAL DEVELOPMENT	Y	N	#	DEVIANCES
			Socialization Cont'd:				
_	_	_	Friendly to both sexes - preference to to same sex.	_	_	_	Poorly socialized, has difficulty relating to peers, often aggressive, needs constant supervision.
_	_	_	Rich imagination, boundless curiosity.	_	_	_	Withdrawn, ritualistic - imitative play.
_	_	_	Follows social rules and fair play.	_	_	_	Oppositional, negative, noncooperative, wilful and contrary.
_	_	_	Is aware of self as a person, has a clear body image and sexual identity.	_	_	_	Feelings of inadequacy, inferiority, may have identity difficulties.
_	_	_	Can recognize and empathize with feelings of others.	_	_	_	Panics, acts "as if" the hurt is his. May be able to empathize with problem children.
_	_	_	Developing "leader - follower" balance. Performs for others.	_	_	_	Intrusive - doesn't appear to understand give and take or concept of "acting", or may be intrusive "show-off".

INDIVIDUAL PROGRAM
PLANNING FORMS

BEHAVIORAL QUESTIONNAIRE

ATTENTIONAL DEFICIT - DEVELOPMENTAL LEARNING DISORDERS

1-Moderate/Normal 2-Somewhat Unusual 3-Poor/Extreme

Behaviors	Rating 1-3
Activity level	___
Aggression	___
Impulsivity	___
Tolerance for frustration	___
Attention span	___
Excitability	___
Restlessness	___
Distractability	___
Intrusiveness	___
Reaction to emotional stimuli	___
Response to discipline	___

SOCIAL COMPETENCY CHECKLIST

Child's Name: ______________________________

Teacher's Name: ____________________________ Date: ________

1-not at all 2-a little 3-moderately well 4-well 5-very well

Please note that 5 represents the most positive rating.

General

___ Feels good about himself or herself
___ Anger, when displayed, is justified
___ Shares things with others
___ Expresses ideas willingly
___ Can accept things not going his way
___ Defends his views under group pressure
___ Resolves peer problems on his own
___ Copes well with failure
___ Is able to question rules that seem unfair or unclear
___ Well liked by peers
___ Makes friends easily
___ Thinks before acting
___ Accepts legitimate imposed limits
___ Expresses needs and feelings appropriately
___ Functions well in unsupervised situations

Interaction with Adults

___ Seeks positive attention
___ Seeks negative attention
___ Controls adult
___ Expresses affection
___ Expresses hostility
___ Complies with direction
___ Role play (mother/father/brother/sister)

SOCIAL COMPETENCY CHECKLIST Cont'd.

Interaction with Peers

___ Attends to peers
___ Leads peer - positive/neutral
___ Leads peer - negative
___ Refuses to follow peer's direction
___ Competes with peer for adult attention
___ Imitates peer
___ Affectionate with peer
___ Hostile towards peer
___ Aggressive with peer for toys/equipment

Social Participation

___ Solitary
___ Onlooker
___ Parallel
___ Associative
___ Cooperative
___ Prefers one peer
___ Prefers small group
___ Prefers large group (4 or more)
___ Transient
___ Same sex
___ Opposite sex
___ Older children
___ Same age children
___ Younger children

Entry into Group Situations

___ Distruptive (tantrum)
___ Threats
___ Passive acceptance
___ Assimilation
___ Solicits entry
___ Organizes own group

SOCIAL COMPETENCY CHECKLIST Cont'd.

Independence

__ Dependent
__ Passive
__ Conforming
__ Self-reliant

Identification

__ Victim
__ Aggressor
__ Provider

Comments: ____

____

GRADUAL SEPARATION FOR YOUNG CHILDREN

Theory of Separation

There are many reasons why children have difficulty separating from a parent. Autistic children (and others for one reason or another) do not readily develop inner visual language and therefore cannot feel comforted when they miss or think of that person. The usual response to separation in such instances is panic. It does little good to have the parent practice gradual separation. More appropriate is to provide the child with a transitional object or a picture, to talk about the parents several times during the morning and to show the picture from time to time. It is often helpful to shorten the time in the preschool with a gradual lengthening as the child becomes more familiar with the environment.

With the other children, particularly those who have experienced hospitalizations, traumatic events and/or unexpected seaparations, gradual separation can help make this process less painful and eventually prove to the child that the parent will return. Practicing of individuating (i.e. the child walking away from the parent, then checking back) may need to take place, first with the parent and possibly with the staff.

Gradual Separation Procedure

1. Parent brings child into room - - stays close or helps with removal of outer wear (teacher should also be close by to help, give directions and eventually take over if possible).

2. If child can't say goodbye at this point without upset, have parent tell the child (or teacher may have to do so) that he/she will sit on a chair and watch for a while. Parent sits on the chair near the door or in an area of interest to the child, shows interest and is supportive but does not get down on the floor with the child to play. Parent is available but not overly

involved. Acceptable for child to sit on the parent's lap, on chair beside her or on floor with a toy.

3. After a short time (this will vary with each child/parent), not longer than 20 minutes, the parent and/or teacher warns the child as caually as possible that the parent will be leaving in two minutes, telling him or her where she will be, what she will be doing.

4. Parent carries through by saying goodbye with the expectation that it will work. Try not to convey anxiety to the child. Even if the child becomes upset, parent leaves. The teacher takes over by distracting or holding and reassuring the child that the parent will be back shortly. Parent is given instruction as to how long to stay away (varies from one second to five minutes in the beginning).

5. Continue to support and encourage the child to participate without pressure in activities which are appealing (check with parent beforehand).

6. Parent returns immediately the child begins to calm or play, goes to the child, informs him/her that she will return shortly or stay for a few minutes, whichever is appropriate at that time. The parent uses the original chair as a transitional object if necessary. The parent must be willing to take time to deal with the separation issue and not push too hard to have it happen quickly.

7. Repeat the above several times during the morning, extending time between returns to the room, taking cues from the child. This procedure may need to be repeated until parent can leave child at the door without upset. The ultimate goal is for the child to develop confidence in himself, trust in others and satisfactory individuation.

SUGGESTED GROUP ROOM STRATEGIES FOR DISRUPTIVE BEHAVIOR

In dealing with children's misbehavior one always starts with the premise that the child needs help rather than is acting deliberately. Give him/her the benefit of the doubt. The most important aspect of changing behavior is to be consistent, calm and firm and to relieve the child of excessive power and/or guilt. Reassure the child that it was the behavior that needed adjustment, that it is over and that the slate is clean.

Physicial Aggression

1. Make child aware of what he has done and reflect child's feelings for him/her, i.e., "you are feeling angry, sad".
2. Discussion (reasoning at child's level).
3. Child resolves problem. Teacher acts as mediator/model.
4. Warning of removal (choice for behavior change).
5. Supportive time-out (on or off chair) with close proximity and support of teacher - return to situation for resolution.
6. Removal with redirection (no option to return).
7. Time-out to break the cycle and allow child to calm followed by opportunity for resolution.
8. Removal from room followed by succesful return and resolution.

Destructive behavior with own activity

1. Awareness, model and verbalize appropriate use of toy/ equipment.
2. State unacceptability of behavior with firmness.
3. Warning of removal of toy.
4. Removal of toy with redirection.
5. Supportive time-out (on or off chair) with close proximity of teacher. Return with child to activity. Resolution and/or change in behavior important. Praise and "start fresh".

Points 7 and 8 as previously outlined may be followed in extreme cases.

Destructive behavior with others activity

1. Awareness and model acceptable behavior.
2. Provide child with own space, tools and activity.
3. Verbalize emotions of both parties and help encourage positive interaction.
4. State unacceptability of behavior with firmness.
5. Warning of consequence.
6. Supportive time-out (on or off chair) with close proximity of teacher -- then return to make amends.

Points 7 and 8 as previously outlined may follow.

Dangerous behavior

1. Awareness and reasoning.
2. Physical removal with explanation and supportive redirection.
3. Physical removal with firmness stating unacceptability of behavior.
4. Change environment (if possible) to avoid dangerous behavior.

Points 5 - 8 may follow depending on individual case.

Behavior management for structured activities

1. Clearly state expectations.
2. Give transitional warning (time limit).
3. Allow transitional object to be used.
4. Physical prompting, i.e. holding hand/stopping play/ save activity/toy.
5. Shape behavior for routine, i.e., bring a wet towel over to wash hands.
6. Time-out procedure if appropriate.

INDICATIONS OF POSSIBLE LEARNING PROBLEMS

3 Year Old

GROSS MOTOR	Unable to roll a large ball Unable to balance on one foot for one second Walks awkwardly Runs stiffly - has difficulty stopping, starting and turning corners Unable to peddle bike Unable to jump over low obstacle Unable to land on both feet when jumping off one step
SPACE	Bumps into objects when walking Unable to crawl under or climb over Holds onto chair (or table) when sitting
FINE MOTOR	Poor pincer grasp Unable to make definite stroke with crayon Unable to copy circle Unable to string beads
VISUAL	Unable to match colors shapes do simple puzzles (3 shapes) Misjudges distance of objects
AUDITORY	Unable to understand directions without visual clues (gestures) Unable to remember simple rhymes and songs
BODY IMAGE	Unable to touch nose, eyes, mouth, arms, legs, feet
BEHAVIOR	Extremely short attention span Unable to remember simple directions Compulsive Does not attempt to dress self Easily frustrated

INDICATIONS OF POSSIBLE LEARNING PROBLEMS

4 Year Old

GROSS MOTOR	Unable to bounce large ball to someone (unable to release) Unable to walk on taped line or 4" walking board Unable to balance on one foot (4 seconds)
SPACE	Unable to walk backwards Misjudges space when walking or crawling (Depth perception) Lifts foot too high or not high enough to walk over something Doesn't understand in front behind, etc.
FINE MOTOR	Unable to cut button snap Thread needle through large holes
VISUAL	Confusion in recognizing shapes and sizes Notices details but misses main point in pictures Faulty memory
AUDITORY	Unable to remember names of body parts - or confuses them Can't roll over from stomach to back Doesn't understand "other side"
VERBAL	Speech poor Has difficulty expressing himself Forgets what he was saying Reverses words or letters Speech clear but language limited
BEHAVIOR	Perseverates - actions verbally Overactive or lethargic Distractible (noises or movements) Inconsistent behavior - knows one day, can't do it next day

MONTHLY REPORT

DATE:

INDIVIDUAL PROGRAM PLANS:

CHILD:

COMMUNICATION:	1.			
	2.			
	3.			
SOCIALIZATION:	1.			
	2.			
	3.			
BEHAVIOURAL:	1.			
	2.			
	3.			
EMOTIONAL	1.			
	2.			
	3.			
COGNITIVE	1.			
	2.			
	3.			
OTHER	1.			
	2.			
	3.			
			IP	T

T = Terminated but still reviewed
IP = In progress

COMMENTS:

STAFF:

DAILY MONITORING FORM

DATE ____________

NUMBER OF ____________ FOR ____________

NUMBER OF ____________

M T W T F S S M T W T F S S

DAYS

145

DATE ____________

NUMBER OF ____________ FOR ____________

NUMBER OF ____________

M T W T F S S M T W T F S S

DAYS

146

TREATMENT PLAN

Child's Name:

Age:

Date:

Developmental Area:

Long-term Goal:

Person(s) Responsible:

Short-term Objective:

Setting: Where:

Who:

When:

How long:

Material:

Methods: Desired Behaviour:

Statement to Child:

Environmental Changes:

Barriers:

Consequences for Acceptable Performance:

to Reduce Barriers:

Progress:

Comments & Notes:

Gen. #2

INDIVIDUAL PROGRAM PLANNING

LONG-TERM GOALS AND SHORT-TERM OBJECTIVES

Child's Name:

Date:

Person Responsible:

*Long-term and short-term objectives will be similarly developed for each developmental area of deficit.

Developmental Area:

Long-Term Goal:

Date of Anticipated Achievement:

Objectives: (short term)	Barriers	Method of Evaluation
1.		
2.		
3.		
4.		

COMMENTS:

INDIVIDUAL PROGRAM PLANNING

LONG-TERM GOALS AND SHORT-TERM OBJECTIVES

Child's Name:

Date:

Person Responsible:

*Long-term and short-term objectives will be similarly developed for each developmental area of deficit.

Developmental Area:

Long-Term Goal:

Date of Anticipated Achievement:

Objectives: (short term)	Barriers	Method of Evaluation
1.		
2.		
3.		
4.		

COMMENTS:

PART II

BEHAVIORALS DISORDERS

CHAPTER 3

ATTENTIONAL DEFICIT DISORDER

A review of the literature points to the on-going confusion and the many shifts over the years as a result of massive research on children with a cluster of symptoms now known as Attentional Deficit Disorder with or without Hyperactivity (ADD/ADHD) as reported in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IIIR; American Psychiatric Association, 1987). ADHD continues to be one of the most studied childhood disorders in terms of nature, prevalence, developmental course, prognosis, management and treatment.

The diagnostic term of ADD or ADHD is an attempt to provide a more precise description of children who, in the past, were referred to as having minimal brain dysfunction or damage, hyperactive or hyperkinetic child syndrome. Although some children may indeed have identifiable brain injury, the majority do not. While there is no doubt that ADD is a common disorder with a common group of symptoms and behaviors, investigators are not in complete agreement on all aspects. Douglas (1984) has concerns about the ADHD label in that it could result in an "unnecessarily constricted conceptualization of the problem." She strongly feels that as well as the more familiar deficits, these children have a "faulty arousal modulation mechanism that fails to generate sufficient arousal or alertness to enable them to cope with the tasks successfully." As well, she maintains that their impairment involves: "(1) the maintenance of attention over time: (2) the extent to which attention is self-directed and organized: (3) the amount of effort that is invested." Roberts (1988), Medical Director, Learning Evaluation Unit, Child Development Clinic, The Hospital for Sick Children is concerned with the large numbers of children being referred who do not have a "true Attentional Deficit Hyperactivity Disorder... (rather) have other causes for their inattention... Other diagnosis being made include language disabilities, non-verbal or social learning disabilities, anxiety disorders, unrecognized gifted children often with concomitant visuo-motor problems and emotionally deprived or disturbed children."

March and Terdal (1988) also express concerns regarding differential diagnosis. They would add to other primary symptoms a deficit in rule-governed behavior which refers to the "ability of language (commands, directions, instructions, descriptions, etc.) or other symbol systems to serve as discriminative stimuli for behavior; situational variations (inconsistent displaying of behaviors in all situations)". They do not entirely agree with DSM-IIIR inference that children with or without hyperactivities show similar deficits. Marsh and Terdal report that results of studies have been conflicting in this regard. From the forgoing it is evident that this disorder is indeed complex.

A further difficulty arises when an attempt is made to differentiate ADD (with or without hyperactivity) from children with learning disabilities. Many of the symptoms and behaviors overlap and it is important to look carefully at this particular aspect. This is especially evident at the preschool level. Standardized testing is necessary to confirm an accurate diagnosis. While symptoms of learning disabilities are thought to be more prevalent in school age children, indicators as well as areas of deficits can readily be picked up at the preschool level. For this reason learning disabilities or indicators in preschoolers will be addressed separately.

There are many definitions available for ADD/ADHD. Karniski's description states that "The child with Attention Deficit Disorder has an intrinsic inability to selectively focus attention, resulting in a short attention span, impulsivity and excessive motor behavior." March and Terdal's definition enlarges somewhat on the above. "ADD/H is a developmental disorder of attention span, impulsivity, and/or overactivity as well as rule-governed behavior, in which these deficits are significantly inappropriate for the child's mental age; have an onset in early childhood; are significantly pervasive or cross-situational in nature; are generally chronic or persistent over time;

and are not the direct result of severe language delay, deafness, blindness, autism or childhood psychosis."

As far back as 1902 George Still described children in his clinic as "quite aggressive, defiant, resistant to discipline, and highly emotional and who showed little self-control". Some of those behaviors resemble the ADHD child. However, more recently other descriptions have appeared with a focus on inattention, hyperactivity and impulsivity. Predictive behaviors are sometimes present in the first days or weeks of postnatal life. For some children infancy can be untroubled and serene with the onset of problem behaviors coinciding with mobility. Early onset behaviors include a child who cries intensely and often; intense reaction to all stimuli; eating and sleeping irregularities and long difficult periods of adjustment to change.

Hyperactivity

ADD/H children are restless, moving and shifting position continually and unpredictably - they move even when it is not appropriate. They are hasty, lacking in control and seek instant gratification. This is not a result of preoccupation or disinterest.

Inattention

They are inattentive, flit about and welcome distractions. These behaviors are different from those of a child who is bored or preoccupied. They resist limit setting, responding with manipulations, whining or temper tantrums. Bribes, threats or punishment are ineffective. They are inconsequential and do not appear to understand cause and effect.

Impulsiveness

Children with ADD are socially inept. Although friendly they are lacking in empathy and are insensitive. They end up with few if any friends. They are accident prone, being careless and uninhibited they engage in physically dangerous behaviors. They are emotionally unstable, lacking in self-control and prone to severe and dramatic mood changes. They are emotionally superficial, with bland affect, usually defensive and denying. As a rule relationships are casual, fleeting and shallow.

A cluster of these attributes are needed since a diagnosis could not be based on one behavior. On the other hand, a child is not likely to show all of them. At the preschool level behaviors such as restlessness, a tendency to be accident-prone and frustration with possible primitive aggression would be most noticeable. Since each behavior could have more than one cause, the tendency of premature diagnosis which reflects only a few of the mentioned behaviors must be avoided. Situational considerations also needs to be analyzed as these "behaviors are least apparent in novel or stressful situations" but would be expected in most familiar locales as a pervasive trait on an on-going basis.

Causation and Prognosis

Although some ADHD children have been difficult from birth, most are identified between three and four years of age. They may differ from other problem children such as those who are defiant/aggressive in that there are usually more delays in language and motor skills, persistent overactivity across environments and difficulties in attending particularly to monotonous, repetitive tasks.

According to most investigators ADHD is commonly under-diagnosed, usually on the basis of lack of knowledge, confusion around symptoms and a reluctance to "label". There is a strong prevalence for these difficulties to be found in males - 3 or 4 :1. This is likely due to the fact that males have a greater susceptibility towards infections or assaults as infants.

Causes proposed for ADHD are numerous but not always backed by empirical facts. Initially brain damage was thought to be the chief cause. However, more recent investigation suggests that fewer than 5% of ADHD children show neurological symptoms consistent with brain damage. Again the proposal that there could be a neurotransmitter dysfunction or imbalance has as yet not been verified. Findings do appear to support some central nervous system mechanism dysfunction. Rigorous investigations on the effects of environmental toxins such as food additives, refined sugars and allergens have not supported these as causal of ADHD. Other investigators have looked at maternal smoking and alcohol consumption with only correlative results. As well, biological predisposition, pregnancy and birth complications giving rise to some disturbance in the nervous system have been considered and are still being investigated.

Research on the role of hereditary transmission across generations has been more positive. Studies show that between 20% to 32% of parents or siblings of ADHD children also have the disorder. Research strongly suggests a genetic predisposition. Environmental and social influences can have a negative or positive impact on the severity and outcome of the disorder. A small percentage of teenagers will have outgrown their childhood ADHD symptoms. However, an estimated 75% will continue to have problems with adjustment to home, school and community.

As adults, 60% will continue to have symptoms but with better abilities to adjust to a variety of situations including job settings. Outcome predictions for adolescents and adults take into consideration such factors as intelligence, emotional stability, self-esteem, degree of aggressive or oppositional behavior.

Early intervention, particularly at the preschool age is crucial as noted by Kinsbourne and Caplan "The longer the child continues to fail... (be it due to nondiagnosis or to ineffective remediation), the less favorable is the prognosis. For even if the neuro-physiological insufficiency should resolve itself spontaneously, a cycle of secondary complications may perpetuate." The best predictor for these children is their cognitive functioning.

It is evident then, that front line workers at the preschool level must be trained and alert to detect relative deficiencies in cognitive areas (such as motor, language), behavioral indicators, and weaknesses in task orientation.

Associated Behaviors

Although there has been much controversy on the DSM-IIIR's definition as being to inclusive with the revision from ADD with and/or without hyperactivity to HDHD, it is a good source of information on the listing of behaviors. Care should be taken in this diagnosis not to included other groups such as conduct or oppositional categories. Such a diagnosis needs to be thoroughly investigated and confirmed by the use of several different testing techniques. Consider the child who may be exhibiting a number of the following behaviors.

Inattentive

- easily distracted
- short attention span
- unable to carry out directions
- poor concentration (needs 1-1, quiet)
- confuses details, rarely finishes an activity

Impulsive

- excitable
- overreaction to emotional stimuli
- needs instant gratification
- disruptive (physically and verbally)

Hyperactive

- always on the go (runs, stands instead of sits)
- constant body movement
- boisterous
- can't take time to listen

Inconsistent and unpredictable
Muscular incoordination (can be inconsistent)
Speech Deficits
Lack of apparent fear
Lack of response to unusual consequences
Perceptual defects
Low frustration tolerance leading to temper tantrums

To provide a more global picture ask yourself these questions:

- Does he/she invade a room?
- Does he often stumble as he walks?
- Does he run, leap and lunge?

- Does he seem to know what is in the room without really looking?
- Even when scanning the room is it accompanied by constant motion?
- Does he climb and balance with surprising agility considering his general incoordination?
- Does the slightest sound or movement cause him to stop and attempt to locate it?
- Does he have trouble identifying objects or sounds against a "noisy" background, becoming agitated and active?
- Does he have difficulty tolerating delay?
- Is he constantly frustrated by small things?
- Does he get out of control during gross motor activities or outside play?
- Is he controlling or negative?
- Does he distinguish between friends and strangers?

Children with a pervasive ADHD disorder will exhibit more severe traits as reported by Brazelton (1986).

> "Extreme Sensitivity - cannot control his reactions to any sensory stimulus, totally unable to shut out sound...
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> Distractibility - can't pay attention to any task no matter how interesting...
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> Activity Level - constant movement, the more complicated the environment, the more active this child becomes...
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> Physical Signs - you can detect a kind of shakiness... especially when he tries to focus on something or tries to reach for it... he tends to overshoot... unsteadiness as he walks or when he gets up.
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> Personality Problems - as if he knows he'll fail at whatever he tries... (this) child begins early to set up barriers against being taught anything - from manipulating a toy to performing a task. He gives up so early, and so completely that he seems hopelessly unreachable."

TREATMENT AND MANAGEMENT

Establishing the diagnosis will be the initial focus for both treatment and management. This will require expertise to provide a complex and intricate balance of a variety of strategies since no single modality can address all of the difficulties.

Multiple approaches must be considered: behavior management strategies focused on improving the primary symptoms; parent training in effective management; individual or small group to address poor self-esteem and peer relationship problems. A cluster of the following behaviors would indicate the need for a formal assessment.

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- Difficulty with turns or delaying gratification.

Long Term Goals

1) Help the child towards self control, competence and positive self-esteem.
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- Reduce as much as possible, visual and auditory stimulation.
- Reduce the number of activities, materials.
- Establish an on-going routine.
- Keep instructions, talking to a minimum.

General Suggestions

- Be aware that these children have difficulty in building a store of knowledge as well as developing problem-solving strategies.
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conceptual strategies put them at a disadvantage.

- They are easily aroused but appear unable to modulate these feelings, behaviors.
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- Be aware of each unique response. The child will need help with all of these issues.

Management Strategies

- Like him and accept him despite his behaviors.
- Be convinced of his value and worthiness.
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- Provide structure (a predictable environment - it provides security for the ADHD child. As inner control is established, it can gradually be reduced or modified).
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- Keep unstructured (or unsupervised) time at a minimum. Present one activity at a time, divide into small units.
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- Use social reinforcement (praise, smile, encourage) and natural consequences (if he finishes an activity reasonably, he gets to choose the next activity etc.).
- Ignore the negative as much as possible (repeat often, provide cues).
- Avoid overstimulation, plan ahead.

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SUGGESTED READINGS

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CHAPTER 4

OPPOSITIONAL DISORDER

The features of Oppositional Disorder vary according to age. Oppositional behavior in a two or even a three year old would be considered normal. In three, four and five year olds some negativism and opposition is expected. It is the intensity and consistency that would cause concern. The most striking feature in an oppositional disorder is the consistent pattern of hostile, negative and defiant behavior, without the more serious behavior of violating the basic rights of others. The consistence and intensity of the behavior stands out sharply in contrast to other children of the same age.

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Typically these behaviors are practiced more freely in the home and may be inhibited in a preschool setting until they feel comfortable and more confident. Once the child gets to know peers and teachers, the resistance and negative responses become "second nature". Although requests may be perfectly reasonable (change in routine, request for help or suggestion to try a new activity), the response is one of resistance, hostility or defiance. In most cases the child will not perceive himself as oppositional or negative and usually justifies his position in terms of unfairness to self in a lengthy, intense tirade. They are argumentative with adults (usually maintaining good language ability) and often physically hurting to peers. Their ability to maintain a verbal position with cunning is surprisingly secure.

Frustration Level

Many of these children can be very touchy, becoming annoyed at seemingly trivial instances. They quickly lose their temper (may engage in temper tantrums), are verbally and physically abusive, swear, exhibit intense anger and remain resentful for a period of time.

Defiant Behavior

These children tend to be defensive about their behavior. Although they do not step too far outside the expected norm, they go to great lengths to defend their rigid position. They appear compelled to prove that they are right and that the adult is wrong. In game playing, it is imperative to them that they win and will openly cheat blatantly denying having done so.

Possible Associated Features

It is important to look beneath the facade at what may be happening to these children. They may be experiencing low self-esteem, mood swings, underlying sources of anger or attentional deficit disorder may be present.

Causation and Prognoses

While there is limited information in the literature on oppositional behavior per se, it is a problem seen consistently in preschool children both in clinics and centres. The problem is more pronounced in the home with many reports, particularly from mothers, regarding the escalation of hostility towards her. Investigation reveals that these children commonly have a very serious parent whose compulsive behavior and need to "be right" may have been the model followed. As well, it was found that parents tend to be overly firm (expectations high) or provide little guidance more often than is the case with other children. Although there is no clear indication of the cause of this disorder it can be seen in mild, moderate or severe form and if not treated can develop into conduct disorder, a much more serious problem. Prognosis is positive with early identification and treatment particularly at the preschool age.

Associated Behaviors

- Screams, kicks, throws self to floor if crossed
- Pushes, hits, bites, bosses peers
- Angry
- Talks back, walks or runs away from adults
- Appears to deliberately do the opposite

- Continually on the move (not hyper)
- Throws toys etc., in response to frustration

TREATMENT AND MANAGEMENT

It is important that behavior which comes under the category of oppositional disorder be recognized and treated at as early an age as possible to prevent the progression to more serious disorders. A child consistently showing a considerable number of the following symptoms will need help in terms of assessment and programming.

1) Disobedient, defiant
2) Negative, refuses direction
3) Temper tantrums or blows-up easily
4) Argumentative
5) Blames others, denies behavior
6) Angry and resentful
7) Spiteful and vindictive
8) Dominates, bullies
9) Restless, hyperactive, inattentive
10) Lies, cheats at games

Some of these children's behavior is extremely troublesome resulting in so frequent scolding and punishing that the punishment means little or nothing - certainly ceases to be a deterrent. Because adults get worn down they actually get by with misbehaving a good deal of the time. As noted by Hallahan (1986) "What must be looked at is the interaction between behavior and the behavior of other people in his or her environment... aggressive antisocial behavior in childhood generally means a gloomy future in terms of social adjustment and mental health".

Long Term Goals

1) To help the child feel more positive about himself, his environment and the people in it.
2) Help the child to realistically understand the consequences of his behavior in such a way that he begins to respect himself and others.

3) Help him realize his potential by means of successes, rewards of acceptable social behavior and the resolution of hostile, aggressive impulses.

General Suggestions

- Because of the history (even at this early age) of rejection, punishment and criticism, it will be necessary to slowly win the child over, convince him that despite all his "obnoxious" ways, he can and will be accepted.
- That is not to say that there will not be fair play and reasonable expectations.
- Research (Patterson 1982) tells us that it is not wise to let children "act out" their aggression. (See management strategies).
- It would be helpful to explore the focus of his anger - this can best be accomplished through acceptance and support verses confrontation or an authoritative approach.
- Since these children cannot tolerate losing, it is best to avoid situations in which the child is placed in a position of "losing face" until such time as he can give in more gracefully. This usually happens only after a trusting relationship has been developed.

Management Strategies

- Go slowly - get to know the child
- Try to ignore or walk around the brash exterior
- Turn the negativism around eg., "Oh, look the sand fell on the floor", thus taken by surprise quickly get him to help clean up. Do this as often as possible providing him with a positive model and positive expectations (even though he may not always respond positively).
- Injecting humor into a situation can be effective in breaking the tension and defensiveness about his behavior.
- The most helpful techniques for acting-out aggressive behavior include.
    a) the modelling of non-aggressive responses to aggressive-provoking behaviors.

b) help the child role-play (rehearse) nonaggressive behavior.

c) reinforce nonaggressive behavior.

d) preventing positive consequences for aggression/anger.

e) using as little counteraggression for punishment as possible (use "time-out" in a positive non-punishing manner or brief social isolation rather than chastising, scolding or threatening).

- Provide structure and activities of interest to prevent wandering and the annoying of peers.
- Gently and slowly over time help him to realize that its ok to make a mistake, lose at a game or not always be the leader (bully).
- Ignore his swearing and verbal abuse but let him know you and the children do not like it. Try to distract him.
- Don't get caught in his arguments or manipulations.
- Help him with his frustration and sadness.

SUMMARY

The oppositional child is an unhappy child, caught in the vicious cycle of driving people away so that he ends up with few friends and fewer positive interactions. This eliminates his chance of learning to make the social adjustment so important for self-esteem and confidence. While causes of this disorder are not clearly understood, many of these children do seem to come from homes that are either rigidly governed or conversely with little or no structure or guidance.

The prognosis is encouraging with early detection and remediation. Left on their own without help, these children may very well progress to the much more serious condition of conduct disorder.

SUGGESTED READING

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PART II

BEHAVIORALS DISORDERS

CHAPTER 3

ATTENTIONAL DEFICIT DISORDER

3 ATTENTIONAL DEFICIT DISORDER

A review of the literature points to the on-going confusion and the many shifts over the years as a result of massive research on children with a cluster of symptoms now known as Attentional Deficit Disorder with or without Hyperactivity (ADD/ADHD) as reported in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IIIR; American Psychiatric Association, 1987). ADHD continues to be one of the most studied childhood disorders in terms of nature, prevalence, developmental course, prognosis, management and treatment.

The diagnostic term of ADD or ADHD is an attempt to provide a more precise description of children who, in the past, were referred to as having minimal brain dysfunction or damage, hyperactive or hyperkinetic child syndrome. Although some children may indeed have identifiable brain injury, the majority do not. While there is no doubt that ADD is a common disorder with a common group of symptoms and behaviors, investigators are not in complete agreement on all aspects. Douglas (1984) has concerns about the ADHD label in that it could result in an "unnecessarily constricted conceptualization of the problem." She strongly feels that as well as the more familiar deficits, these children have a "faulty arousal modulation mechanism that fails to generate sufficient arousal or alertness to enable them to cope with the tasks successfully." As well, she maintains that their impairment involves: "(1) the maintenance of attention over time: (2) the extent to which attention is self-directed and organized: (3) the amount of effort that is invested." Roberts (1988), Medical Director, Learning Evaluation Unit, Child Development Clinic, The Hospital for Sick Children is concerned with the large numbers of children being referred who do not have a "true Attentional Deficit Hyperactivity Disorder... (rather) have other causes for their inattention... Other diagnosis being made include language disabilities, non-verbal or social learning disabilities, anxiety disorders, unrecognized gifted children often with concomitant visuo-motor problems and emotionally deprived or disturbed children."

March and Terdal (1988) also express concerns regarding differential diagnosis. They would add to other primary symptoms a deficit in rule-governed behavior which refers to the "ability of language (commands, directions, instructions, descriptions, etc.) or other symbol systems to serve as discriminative stimuli for behavior; situational variations (inconsistent displaying of behaviors in all situations)". They do not entirely agree with DSM-IIIR inference that children with or without hyperactivities show similar deficits. Marsh and Terdal report that results of studies have been conflicting in this regard. From the forgoing it is evident that this disorder is indeed complex.

A further difficulty arises when an attempt is made to differentiate ADD (with or without hyperactivity) from children with learning disabilities. Many of the symptoms and behaviors overlap and it is important to look carefully at this particular aspect. This is especially evident at the preschool level. Standardized testing is necessary to confirm an accurate diagnosis. While symptoms of learning disabilities are thought to be more prevalent in school age children, indicators as well as areas of deficits can readily be picked up at the preschool level. For this reason learning disabilities or indicators in preschoolers will be addressed separately.

There are many definitions available for ADD/ADHD. Karniski's description states that "The child with Attention Deficit Disorder has an intrinsic inability to selectively focus attention, resulting in a short attention span, impulsivity and excessive motor behavior." March and Terdal's definition enlarges somewhat on the above. "ADD/H is a developmental disorder of attention span, impulsivity, and/or overactivity as well as rule-governed behavior, in which these deficits are significantly inappropriate for the child's mental age; have an onset in early childhood; are significantly pervasive or cross-situational in nature; are generally chronic or persistent over time;

and are not the direct result of severe language delay, deafness, blindness, autism or childhood psychosis."

As far back as 1902 George Still described children in his clinic as "quite aggressive, defiant, resistant to discipline, and highly emotional and who showed little self-control". Some of those behaviors resemble the ADHD child. However, more recently other descriptions have appeared with a focus on inattention, hyperactivity and impulsivity. Predictive behaviors are sometimes present in the first days or weeks of postnatal life. For some children infancy can be untroubled and serene with the onset of problem behaviors coinciding with mobility. Early onset behaviors include a child who cries intensely and often; intense reaction to all stimuli; eating and sleeping irregularities and long difficult periods of adjustment to change.

Hyperactivity

ADD/H children are restless, moving and shifting position continually and unpredictably - they move even when it is not appropriate. They are hasty, lacking in control and seek instant gratification. This is not a result of preoccupation or disinterest.

Inattention

They are inattentive, flit about and welcome distractions. These behaviors are different from those of a child who is bored or preoccupied. They resist limit setting, responding with manipulations, whining or temper tantrums. Bribes, threats or punishment are ineffective. They are inconsequential and do not appear to understand cause and effect.

Impulsiveness

Children with ADD are socially inept. Although friendly they are lacking in empathy and are insensitive. They end up with few if any friends. They are accident prone, being careless and uninhibited they engage in physically dangerous behaviors. They are emotionally unstable, lacking in self-control and prone to severe and dramatic mood changes. They are emotionally superficial, with bland affect, usually defensive and denying. As a rule relationships are casual, fleeting and shallow.

A cluster of these attributes are needed since a diagnosis could not be based on one behavior. On the other hand, a child is not likely to show all of them. At the preschool level behaviors such as restlessness, a tendency to be accident-prone and frustration with possible primitive aggression would be most noticeable. Since each behavior could have more than one cause, the tendency of premature diagnosis which reflects only a few of the mentioned behaviors must be avoided. Situational considerations also needs to be analyzed as these "behaviors are least apparent in novel or stressful situations" but would be expected in most familiar locales as a pervasive trait on an on-going basis.

Causation and Prognosis

Although some ADHD children have been difficult from birth, most are identified between three and four years of age. They may differ from other problem children such as those who are defiant/aggressive in that there are usually more delays in language and motor skills, persistent overactivity across environments and difficulties in attending particularly to monotonous, repetitive tasks.

According to most investigators ADHD is commonly under-diagnosed, usually on the basis of lack of knowledge, confusion around symptoms and a reluctance to "label". There is a strong prevalence for these difficulties to be found in males - 3 or 4 :1. This is likely due to the fact that males have a greater susceptibility towards infections or assaults as infants.

Causes proposed for ADHD are numerous but not always backed by empirical facts. Initially brain damage was thought to be the chief cause. However, more recent investigation suggests that fewer than 5% of ADHD children show neurological symptoms consistent with brain damage. Again the proposal that there could be a neurotransmitter dysfunction or imbalance has as yet not been verified. Findings do appear to support some central nervous system mechanism dysfunction. Rigorous investigations on the effects of environmental toxins such as food additives, refined sugars and allergens have not supported these as causal of ADHD. Other investigators have looked at maternal smoking and alcohol consumption with only correlative results. As well, biological predisposition, pregnancy and birth complications giving rise to some disturbance in the nervous system have been considered and are still being investigated.

Research on the role of hereditary transmission across generations has been more positive. Studies show that between 20% to 32% of parents or siblings of ADHD children also have the disorder. Research strongly suggests a genetic predisposition. Environmental and social influences can have a negative or positive impact on the severity and outcome of the disorder. A small percentage of teenagers will have outgrown their childhood ADHD symptoms. However, an estimated 75% will continue to have problems with adjustment to home, school and community.

As adults, 60% will continue to have symptoms but with better abilities to adjust to a variety of situations including job settings. Outcome predictions for adolescents and adults take into consideration such factors as intelligence, emotional stability, self-esteem, degree of aggressive or oppositional behavior.

Early intervention, particularly at the preschool age is crucial as noted by Kinsbourne and Caplan "The longer the child continues to fail... (be it due to nondiagnosis or to ineffective remediation), the less favorable is the prognosis. For even if the neuro-physiological insufficiency should resolve itself spontaneously, a cycle of secondary complications may perpetuate." The best predictor for these children is their cognitive functioning.

It is evident then, that front line workers at the preschool level must be trained and alert to detect relative deficiencies in cognitive areas (such as motor, language), behavioral indicators, and weaknesses in task orientation.

Associated Behaviors

Although there has been much controversy on the DSM-IIIR's definition as being to inclusive with the revision from ADD with and/or without hyperactivity to HDHD, it is a good source of information on the listing of behaviors. Care should be taken in this diagnosis not to included other groups such as conduct or oppositional categories. Such a diagnosis needs to be thoroughly investigated and confirmed by the use of several different testing techniques. Consider the child who may be exhibiting a number of the following behaviors.

Inattentive

- easily distracted
- short attention span
- unable to carry out directions
- poor concentration (needs 1-1, quiet)
- confuses details, rarely finishes an activity

Impulsive

- excitable
- overreaction to emotional stimuli
- needs instant gratification
- disruptive (physically and verbally)

Hyperactive

- always on the go (runs, stands instead of sits)
- constant body movement
- boisterous
- can't take time to listen

Inconsistent and unpredictable
Muscular incoordination (can be inconsistent)
Speech Deficits
Lack of apparent fear
Lack of response to unusual consequences
Perceptual defects
Low frustration tolerance leading to temper tantrums

To provide a more global picture ask yourself these questions:

- Does he/she invade a room?
- Does he often stumble as he walks?
- Does he run, leap and lunge?

- Does he seem to know what is in the room without really looking?
- Even when scanning the room is it accompanied by constant motion?
- Does he climb and balance with surprising agility considering his general incoordination?
- Does the slightest sound or movement cause him to stop and attempt to locate it?
- Does he have trouble identifying objects or sounds against a "noisy" background, becoming agitated and active?
- Does he have difficulty tolerating delay?
- Is he constantly frustrated by small things?
- Does he get out of control during gross motor activities or outside play?
- Is he controlling or negative?
- Does he distinguish between friends and strangers?

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It is important to look beneath the facade at what may be happening to these children. They may be experiencing low self-esteem, mood swings, underlying sources of anger or attentional deficit disorder may be present.

Causation and Prognoses

While there is limited information in the literature on oppositional behavior per se, it is a problem seen consistently in preschool children both in clinics and centres. The problem is more pronounced in the home with many reports, particularly from mothers, regarding the escalation of hostility towards her. Investigation reveals that these children commonly have a very serious parent whose compulsive behavior and need to "be right" may have been the model followed. As well, it was found that parents tend to be overly firm (expectations high) or provide little guidance more often than is the case with other children. Although there is no clear indication of the cause of this disorder it can be seen in mild, moderate or severe form and if not treated can develop into conduct disorder, a much more serious problem. Prognosis is positive with early identification and treatment particularly at the preschool age.

Associated Behaviors

- Screams, kicks, throws self to floor if crossed
- Pushes, hits, bites, bosses peers
- Angry
- Talks back, walks or runs away from adults
- Appears to deliberately do the opposite

- Continually on the move (not hyper)
- Throws toys etc., in response to frustration

TREATMENT AND MANAGEMENT

It is important that behavior which comes under the category of oppositional disorder be recognized and treated at as early an age as possible to prevent the progression to more serious disorders. A child consistently showing a considerable number of the following symptoms will need help in terms of assessment and programming.

1) Disobedient, defiant
2) Negative, refuses direction
3) Temper tantrums or blows-up easily
4) Argumentative
5) Blames others, denies behavior
6) Angry and resentful
7) Spiteful and vindictive
8) Dominates, bullies
9) Restless, hyperactive, inattentive
10) Lies, cheats at games

Some of these children's behavior is extremely troublesome resulting in so frequent scolding and punishing that the punishment means little or nothing - certainly ceases to be a deterrent. Because adults get worn down they actually get by with misbehaving a good deal of the time. As noted by Hallahan (1986) "What must be looked at is the interaction between behavior and the behavior of other people in his or her environment... aggressive antisocial behavior in childhood generally means a gloomy future in terms of social adjustment and mental health".

Long Term Goals

1) To help the child feel more positive about himself, his environment and the people in it.
2) Help the child to realistically understand the consequences of his behavior in such a way that he begins to respect himself and others.

3) Help him realize his potential by means of successes, rewards of acceptable social behavior and the resolution of hostile, aggressive impulses.

General Suggestions

- Because of the history (even at this early age) of rejection, punishment and criticism, it will be necessary to slowly win the child over, convince him that despite all his "obnoxious" ways, he can and will be accepted.
- That is not to say that there will not be fair play and reasonable expectations.
- Research (Patterson 1982) tells us that it is not wise to let children "act out" their aggression. (See management strategies).
- It would be helpful to explore the focus of his anger - this can best be accomplished through acceptance and support verses confrontation or an authoritative approach.
- Since these children cannot tolerate losing, it is best to avoid situations in which the child is placed in a position of "losing face" until such time as he can give in more gracefully. This usually happens only after a trusting relationship has been developed.

Management Strategies

- Go slowly - get to know the child
- Try to ignore or walk around the brash exterior
- Turn the negativism around eg., "Oh, look the sand fell on the floor", thus taken by surprise quickly get him to help clean up. Do this as often as possible providing him with a positive model and positive expectations (even though he may not always respond positively).
- Injecting humor into a situation can be effective in breaking the tension and defensiveness about his behavior.
- The most helpful techniques for acting-out aggressive behavior include.
    a) the modelling of non-aggressive responses to aggressive-provoking behaviors.

  b) help the child role-play (rehearse) nonaggressive behavior.
  c) reinforce nonaggressive behavior.
  d) preventing positive consequences for aggression/anger.
  e) using as little counteraggression for punishment as possible (use "time-out" in a positive non-punishing manner or brief social isolation rather than chastising, scolding or threatening).

- Provide structure and activities of interest to prevent wandering and the annoying of peers.
- Gently and slowly over time help him to realize that its ok to make a mistake, lose at a game or not always be the leader (bully).
- Ignore his swearing and verbal abuse but let him know you and the children do not like it. Try to distract him.
- Don't get caught in his arguments or manipulations.
- Help him with his frustration and sadness.

SUMMARY

The oppositional child is an unhappy child, caught in the vicious cycle of driving people away so that he ends up with few friends and fewer positive interactions. This eliminates his chance of learning to make the social adjustment so important for self-esteem and confidence. While causes of this disorder are not clearly understood, many of these children do seem to come from homes that are either rigidly governed or conversely with little or no structure or guidance.

The prognosis is encouraging with early detection and remediation. Left on their own without help, these children may very well progress to the much more serious condition of conduct disorder.

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CHAPTER 5

CONDUCT DISORDER

5 CONDUCT DISORDER

Conduct Disorder is on a continuum with oppositional disorder. It has all the features plus other more serious behaviors. These children are likely to exhibit such characteristics as disobedience, destructiveness, jealousy, aggressiveness, violation of the rights of others, cruelty to people and animals. Defiance of authority with inadequate feeling of guilt attached to behaviors such as seriously hurting peers, adults or animals, stealing, lying and cheating is of concern.

While we rarely consider the normal "borrowing" of peer's toys, distorting to defend against punishment or cheating to win a board game as serious or even abnormal behavior in preschoolers, the intent, intensity and purposefulness of the conduct disordered child leaves little doubt of the seriousness of the behaviors. Preschool children are more likely to be diagnosed as having oppositional disorder. However, the severity of behaviors and resistance to treatment are indicators of progression to the more serious diagnosis of conduct disorder. It has been well documented that children, by the age of five, can and do exhibit behaviors listed in the conduct disordered category.

Antisocial Behaviors

Antisocial behaviors include attitude towards peers. They tend to dominate, threaten and bully other children. Such behavior can escalate to physically hurting, with limited responsibility for their actions. Furthermore, no guilt is expressed although blame is usually assigned to the victim or some other cause. As well, they are often cruel and hurting to animals, again with no indication of guilt or conscience. Sulking, swearing, arguing, demanding, and screaming with defiant disobedience is commonplace. Lying and cheating is usually planned (or done on the spot) and deliberate.

Aggressiveness

Frustration tolerance is low, can quickly take the form of threats or actual attack. These children have few friends but do gravitate to peers with similar problems.

Delinquent Behaviors

Destruction of property (own or others) appears to be in response to anger or hostility. They are not above stealing from parents, friends or stores. Some of these children become obsessed with matches and the lighting of fires both in the home and outside.

Causation and Prognosis

A great deal more research and investigation is needed on possible cause(s) of the syndrome. Some recent investigation (Patterson 1982) suggests that these children suffer from social incompetence, contributing to inappropriate peer relationships. In addition, it was found that cognitive variable may also be involved. Dodge (1980) notes that "aggressive children engage in the distortion of social cues in peer interaction in such a way that they are likely to attribute hostile intent to others in situations in which such intent is ambiguous or absent." Allen (1976) found a close association between conduct disorders and attention deficit disorder with hyperactivity and "that hyperactivity may be the driving force in conduct-disordered children.

There is increasing awareness of the diversity, the multiple causal factors and the need for comprehensive assessments. Recent data suggests that treatment and prognosis are dependent on the severity, pervasiveness and duration of the problem. Early intervention is a must to prevent these children becoming severe delinquents, habitual truants and violators of the law.

Associated Behaviors

- Boisterous and noisy
- Inattentive and destructible
- Aggressive, and threatening behavior towards peers
- Engages in attention-seeking behavior, "shows-off"

- Pouts and sulks
- Is disruptive and demanding

TREATMENT AND MANAGEMENT

Before treatment or the setting up of particular programming on an individual or group basis, it must first be determined if indeed the child is showing behaviors characteristic of the conduct-disordered type. This may mean careful observation (possibly the use of several of the screening tools supplied in Chapter 2) or a referral for an in-depth assessment. Behaviors indicative of a conduct disorder would include a cluster of the following

- Violation of the rights of others.
- Destructiveness of own or others property.
- Fighting, hitting, assaulting.
- Untrustworthy, dishonest, lies.
- Profanity, abusive language.
- Sadness, unhappiness.
- Running around (wandering away).
- Disobedient, defiant.
- Denies mistakes, blames others.
- Few if any, indications of guilt.

Other behaviors might include bedwetting, stealing, crying, complaining, fire setting, soiling, temper tantrums.

Since recent information has indicated that these children may also have difficulties in areas such as attentional deficits, cognitive perception and social relating, possible deficits and functioning levels would be helpful in terms of treatment and programming. To date the preferred treatment appears to include behavior management in the home as well as in the centre or school. Residential placement, may become necessary.

Long-term Goals

1) To help the child achieve reasonable social and occupational adjustment as adults.

2) To intervene (and possibly change) behaviors that are unacceptable, cause harm to others or self.
3) To raise self-esteem, remediate gaps in social and cognitive functioning.

General Suggestions

- Since one predisposing factor is likely to be rejection, acceptance will be an important issue.
- Most of these children have experienced inconsistent management with harsh, rigid (or conversely very little) discipline. Firm and consistent but not punitive rules and regulation will be needed.
- Consistent adults in his environment will develop trust and improved responses.
- Self-esteem is usually low although carefully covered with a brash and sometimes cruel exterior. Efforts to raise one and ignore the other could possibly eliminate some of the inappropriate behavior.
- General structure with plenty of activities to keep him busy and "on track" would be helpful.

Management Strategies

- Ignore the brash, demanding exterior.
- Move in providing firm, fair rules with appropriate consequences (removal, extra chores, whatever makes an impact). End it cleanly and start fresh.
- Be alert for a crack in the facade - use it to help him.
- Allow some leeway with "cheating" so that he can win but let him know that you are aware. Provide a model of non-competitiveness, flexibility.
- Investigate **why** he steals, lies - talk it over rather than confront.
- Structure the environment so he has less need to be a bully, shout and scream - eliminate activities etc., that causes altercations until he is better able to cope.
- Be aware of his unhappiness, help him to enjoy his world.

- Provoke appropriate feelings of guilt whenever possible (may have to rotely learn this).

Medication

According to Read (1979) "A few patients will respond to pharmacologic interventions which attempts to increase their often very low anxiety to more normal levels." It may also increase tolerance for ordinary activities and to learn from experience. Children who are anuretic can sometimes be helped by medication. Any medication must be carefully monitored by the family and their physician.

SUMMARY

Children who project their problems in acting-out, aggressive and demanding behavior are engaged in a vicious cycle. Their behavior makes positive interactions with peers and adults impossible, thus they are less likely to learn to make social adjustments or to feel accepted and successful.

Comprehensive assessments are necessary since appropriate treatment and prognosis are tied to the duration and severity of the disorder. Early identification at the preschool level holds more promise in terms of preventing a pervasive disorder since behavior is more flexible at this young age.

Acceptance, a structured environment, consistent and fair rules and guidance with consistent and caring adults can make a difference. Family therapy to continue the consistency, firm limits and support should be part of the treatment.

Medication can sometimes be helpful and needs to be tried particularly with the more severely affected children.

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PART III

DEVELOPMENTAL DISORDERS

CHAPTER 6

AUTISM

Every autistic child has their own individual basic personality making them different from any other diagnosed autistic child. Furthermore, autism may be present in degrees varying from very mild to very severe. In generalizing descriptions of this disorder rarely would a child "fit" exactly or have all the symptoms described. These children change as they mature and the problem may diminish or in some cases all but disappear. However, most children in early childhood present with some common behavior patterns.

As infants it appears that some develop normally for a year or two although many parents in hindsight report that their "perfect" babies were in fact infants who rarely cried, were content to lay in their cribs undisturbed for lengthy periods of time simply looking at a pattern on the blanket or scratching the bumper pads. They were not particularly interested in being held or cuddled. Other infants engaged in very different behavior, screaming both day and night. They showed particular distress upon waking and could not be comforted.

In either case these babies rarely readied themselves to be picked up or were comforted when they were held. Some rocked or banged their heads. They often become fascinated with a particular toy, light or pattern while at the same time showed no interest in what was happening around them. They did not try to attract the attention of their mothers as normal children do.

These children sit, teeth and crawl within the normal developmental stages. They may also smile but on closer inquiry it is usually in response to tickling or being bounced up and down rather than when looking directly at one's face. With many the actual walking takes place later than usual with the child showing little or no interest in exploring his environment.

Between the age of two to five, parents begin to become more aware of the child's unusual behavior. Young autistic children are almost always healthy and beautiful in appearance. They do not use their large lovely eyes to look directly at others but remain aloof and isolated. Interest is more likely to be shown in specific items, rituals, routines which if changed or disturbed can cause prolonged panic or fury which may be turned off abruptly. These are the surface behaviors of severe problems in many areas which interfere with understanding of the world.

Response to Sounds

The autistic child very often ignores a loud noise while the slightest sound across the room can draw him like a magnet. Some sounds such as the ringing of a bell, the pounding of sticks on different surfaces may cause fascination and be indulged in over and over. On the other hand, some sounds may be extremely distressing causing the child to cover his ears or run away. Strangely, these children do not appear to be sensitive to their own screams. All of these responses can take place within a short period of time.

Communication Difficulties

The spoken word has no more significance than sounds in the environment such as the honking of a horn, the wind in the trees or thunder. He simply ignores language although in time he will begin to pick up on key words. This, however, is of little use to him as he is unable to understand the connectors nor is he able to read other cues that might help him in understanding what is being asked of him. The beginning of comprehension comes slowly and is of a limited basic nature. Wing (1969), Ruther (1978) and others have done studies in comparing the autistic child with blind or deaf children. It was found that autistic children, like blind children, do not appear to be able to evoke visual images. As noted by Rutler "Symbols and internal representations develop through an interaction between an individual and his environment. If environmental input is severely restricted, as in the deaf-blind, there is little on which these representations can be based". It would seem that with the autistic child, even more pervasive than a language impairment, is the underlying problem of processing in terms of the development of representational and symbolic systems.

The child's inability to understand language, gesture or facial expression often leads to poor cuing or incorrect interpretation as he responds only to the tone, movement or exaggerated gestures - he may laugh heartily at being scolded or conversely become totally panicked. Complicated instructions can cause confusion, anger or withdrawal. Even when they are capable of responding accurately to a single dimension, adding another will cause a sudden break from mastery to utter incomprehension. As noted by Rutler (1978) "The autistic child, however good his speech, seems locked into a concrete world in which only one dimension can be responded to at a time."

The acquisition of language varies greatly. Some remain mute while most do learn language although much later than normal. Usually prognosis for autistic children is based on the age at which the child is able to at least parrot words or phrases. Although words seem to have little meaning, many children can imitate exactly down to pitch and accent commercials, advertising and such. The child can become mesmerized with a particular show, such as the child who loved "Bowling for Dollars". Every time he heard a series of numbers or sound similar to bowling pins falling, he immediately went into the action, complete with commentary. This delayed "echolalia" can occasionally be appropriately used. This, of course, is bound to happen as most phrases are repeated over and over and eventually will fit the situation. Autistic children, when under stress, often run through their total repertoire of words and phrases. Eventually the child will begin to produce phrases of his own which are usually easily identified by the slow and painful process and the many mistakes in grammar and pronoun reversal, others became quite adept with imitative language and one must listen closely to realize that actual understanding is limited. Little David was one of those who could use bits and pieces from his environment, sounding as if both expressive and comprehensive language were intact as he plaintively said "what am I going to do Mick, my parents are divorce", yet he had little or no understanding of the actual implications. They have particular difficulty with items which can have several labels such as couch, sofa; pot, saucepan, etc. On the other hand, there are those who can rattle off book titles, store names without the least understanding. An example is the child who became fascinated with Canadian Tire stores. He carried their catalogue constantly and searched the street for Canadian Tire signs whenever he was in the car. Some children can read well but without any sense of understanding. Paul could actually read with the book held upside down but could not relate even the simplest story. Autistic children's speech usually have a mechanical quality and they can have difficulty controlling loudness and flow. They are unable to think with language or to create language of their own initially.

To add to their difficulties they do not understand or use gestures to communicate. In the early years their only language is indiscriminate screaming or grabbing someones hand to use as a facilator in opening doors, turning taps, getting food etc. Ability to understand and respond usually improves with appropriate treatment. This ability is often related to degree of impairment. Some, to further confuse parents (and others) are peudo-independent having learned that they often must respond to their own needs. They can very adeptly get food from the fridge, find cookies, cereal etc.

Perception

Young autistic children rarely give direct eye contact for any length of time but rather dart rapid glances at people and objects.

The absence of any mechanism for understanding the environment results in social avoidance and poor eye contact. The exception is the fixed and prolonged gaze given to items of fascination. Their ability to scan pictures (or their environment generally) is unusual - they tend to pick out small pieces of the whole or to look for the "missing" piece at the side of the picture. This is probably a reflection of their difficulty in understanding "the whole" of anything. Rapidly changing environments such as stores or even a change in a familiar room can result in upset. Trying to involve the child in situations he cannot comprehend may produce distress and consequently overarousal followed by attempts at avoidance. Withdrawal is much less in evidence when a task is within the childs capabilities. They seem to use peripheral vision or the part of the eye that attends to movement and outline rather than the part which perceives fine detail. Often autistic children can find their way in the dark as well in the daytime.

The Senses (touch, taste, smell)

Autistic children seem to explore their world through the senses. Many love the feel of certain objects or materials, responding to the texture. Many mouth and taste almost everything they come in contact with. It is often difficult to discourage the tasting and eating of inedible products such as playdough, cigarettes, etc. They are particularly sensitive to smell and can be alerted through this sense when a parent enters the room. Many times these children are observed gently touching their mothers face again reminisced of a blind child. Sammy loved to explore the therapist's face once he conquered his fear, although it took much longer for him to look directly into her face. Although they reject touching (causes overarousal) they love to be tickled, tumbled and enjoy rough house games. Many have difficulty switching from smooth baby food to lumpy food and insist on having food mashed for longer then normal.

On the other hand, Cohen (1981) has noted that such children appear to have difficulty regulating sensory messages which regulate arousal and attention. Cohen's research leads him to observe that

> "The children may be almost habitually in a state of hyperviligence... may be associated with recurrent cognitive confusion and a compensatory withdrawal and turning inward of attention to avoid environmental bombardment. Far from trying to be contrary or to cause pain and grief, the autistic child, impaired cognitively and attentionally may be simply trying to impose order in his world".

This inability to regulate could account for the unpredictable and unusual response to pain, heat, cold. Amber was a 4 year old who under stress, turned to picking at sores on her legs without any apparent response to the pain that should normally accompany this behavior.

Resistance to Change, Ritualist or Unusual Movements

Some autistic children are distinguishable by their unusual bodily movement. Some flap their hands, make facial grimaces, jump up and down, wander about or have specific rituals such as running an invisible course touching certain objects at either end. They walk on tip toe, flap their feet as they walk or use a stiff-legged gait. A few spin without any evidence of dizziness. Many use their fingers or objects in an unusual fashion near their eyes. These movements can become pronounced and prolonged when excited or while gazing at round or moving objects, string, blocks, balls etc.

In contrast to the clumsy movement, some children are extremely graceful, are able to climb and balance surprisingly well. Some may have good fine motor coordination, others may not. However, nearly all are immature in the way they move. They tend to have difficulty coping movements, usually reversing what they see (point up instead of down). They usually cannot hop or skip and have problems with left-right, back-front.

All Autistics display bazaar or ritualistic behaviours to some degree. They can become preoccupied with certain objects (car wheels, records and record players) or routines (insistence on taking the same route, bedtime, etc.). Paul filled his pockets with bottle caps and could not control his obsession with vacuum cleaners. Years later the reappearance of his therapist brought back this obsession when he was able to recall details of the vacuum that should have been long forgotten.

Autistic children resist change of any kind in their environment, insisting that the same precise route be taken to school each day or only certain clothes be worn. Chris insisted on circling his chair three times before he could sit down.

These rituals are not so surprising in light of their inability to understand an ever changing world. They cling to routines, sameness and become very upset with the slightest change.

Social Withdrawal

One of the major symptoms of autism is the inability to relate to others or social withdrawal. They often behave as if others do not exist, they seem to look through people, walk over peers and toys (usually with care not to step on anyone or thing) without hesitation. Even when there is contact to satisfy a need, they will promptly turn away once satisfied. As an infant they seem happiest when alone and usually refrained from any affectionate display. They may be very fearful of strangers or may treat them in the same way as they do family members. Whether withdrawn or more outgoing, interaction with others is inappropriate or unusual.

These children treat peers in a similar manner. They ignore them, becoming interested only with "silly" or excessive movement. At such times, they appear to be intrigued laughing uproariously. Some do progress to showing interest as they stand near watching activities. Others may interfere without any understanding of the situation, grabbing a toy and becoming excessively upset with any type of intervention. Surprisingly, some children who have expressed fear or panic of people may suddenly sit for a moment in the midst of a group.

Often they seem cut off. Wing's description is apt... "in a world of his own, completely absorbed in his own armless activities". However, they can respond to adults who show understanding and persist in non-threating ways to break through the barrier. They tend to become more affectionate with maturity acting at five or six as one would have expected at a much earlier age. This same belated improvement is seen in the response to toys although generally autistic children seldom use toys in a creative or imaginative way.

The development of social requirements is particularly difficult. Between the ages of two to five they tend to be upset in social situations, scream, grab, tear books and papers, kicking and biting in response to fear, panic or the need for instant gratification. Autistic children do not lie, they do not understand why one should be discrete and therefore often make embarrassing remarks in public once they have acquired language. Their naively can lead to the unintentional hurting of other people's feelings.

Emotional Responses

Autistic children display unusual fears, often of seemingly harmless things, an elevator, a pair of shoes that hurt, balloons. Chris could not step over a puddle and insisted on walking around it or returning to the house. On the other hand he loved the rain, making no connection between the two. Such fears can cause great hardships on the family.

Despite these fears they can be unaware of real dangers. They have no idea of the danger of running onto the road, some seeming to enjoy seeing cars stop abruptly to avoid hitting them. When they are fearful or in a panic it is difficult to comfort them and it is only with excessive stress that they finally give in to tears. At such times they can only be comforted by their mothers or someone they trust.

Special Skills

Some of these children have unusual skills. It is not surprising that parents and professionals alike feel that there must be a "key" that will resolve the problems of autism. The special skills together with their often very attractive appearance gives the impression of a normal, intelligent child.

These skills rarely involve language. They are usually good with puzzles, construction or mechanical toys or anything electrical. Dougie, who at ten continues to have academic and social difficulties is a whiz at mechanical or electrical repairs around the house. His greatest pleasure is to assist his dad in fixing his car or installing electrical wiring. Many are musically inclined.

Truly gifted autistic children are rare. Memory for places, music, numbers, are a function of the right hemisphere while language is a left hemisphere function. Generally, autistic children enjoy activities which do not require language.

Asperger's Syndrome

Limited recent investigation (Szatmari et. al, 1989; Gillberg and Gillberg, 1988 and Delong and Dewyer, 1988) of Asperger's Syndrome (AS) reveals some interesting information. To quote Szatmari and Bremner:

> "The term Asperger's Syndrome (AS) refers to a clinical picture characterized by social isolation in combination with odd and eccentric behavior. While the Syndrome has been recognized for some time, diagnostic criteria for the disorder have not yet been established or evaluated... The sex ratio, family history, and presence of neurologic disease in some AS cases, suggest that the etiology of the disorder is similar to that of autism."

Gillberg comments that AS appears to be more common than infantile autism in the 10-26 per 10,000 range. Also questioned is the possibility that AS may in fact be on a continuum with autism.
Results of Szatmari's study suggests:

> "While the AS and autistic subjects had similar social impairments towards peers, the AS subjects did not show the lack of social responsiveness..., the deviant aspects of language development (echolalia, and pronoun reversal) and the lack of imaginative play seen in autistics... Those findings suggest that children with AS have a type of pervasive development disorder (PDD) both similar to and different from, classical autism... Our conclusion was that the disorders share a common etiology but differ primarily on severity."

It should be noted that DSM-IIIR considers Infantile Autism to be a pervasive development disorder (PDD) but specific to diagnostic criteria for autism.

Causation and Prognosis

Research in search of cause and cure has been on-going since 1943 when Dr. Leo Kanner first described symptoms of autism. Although there has been progress in understanding and the hypothesis that the problems were emotional in origin or that parents caused autism by how they interacted with the child have definitely been ruled out, we are no closer to a definite cause.

Currently, autism as a single entity is questioned. Inborn errors of metabolism is a theory that continues to be researched as is unique impairment of the left hemisphere without takeover of the critical functions of the opposite hemisphere. Some studies point to a genetic factor and the importance of biological hazards in the perinatal period. Results of multiple research points to the possibility that autism most likely does not have a single cause, but rather is very complex and varies from child to child.

Prognosis during the preschool years is variable and one must take a wait-and-see attitude. DeMyer (1979) states that "If the child is capable of accelerated progress, it usually begins between the ages of 4 to 6 years and occurs in those preschool autistic children whose general development quotients are 60 or above." Usually the prognosis is more promising if a child develops the ability to speak in the preschool years, although a prediction cannot be made with any exactness.

Associated Behaviors

- Running, screaming, flapping of hands etc., in response to fear or panic caused with direction, touching or intrusion.
- Repetitive speech or screaming (immediate or delayed echolalia) as a substitute for communicative language, or absence of language.
- Bazaar movement of body, and unusual use of toys.
- Withdrawal or unaware intrusive behavior.
- A tendency to use certain objects excessively (upset when used or touched by others).
- Constant movement, flitting.

TREATMENT AND MANAGEMENT

Should a child be displaying six out of nine of the following symptoms, an indepth assessment by professionals familiar with the syndrome is essential.

1) Severe difficulties with social relationships.
2) Severe communication problems.
3) Ritualistic, bazaar or compulsive behavior.
4) Toileting, sleeping or feeding difficulties.
5) Unusual anxieties and fears.
6) Perceptual problems (vision, hearing, touch, smell, taste).
7) Intellectual impairment.
8) Intense resistance to change and attachment to objects, routines.
9) Unusual use of toys, inability to play.

It is important in terms of management and treatment that the child's level of function, areas of strengths and weakness, emotionality and emerging skills be used as a guideline in working with each individually. Since there are four or five children who show marked autistic features in every 10,000 with a three to one high boy/girl ratio, a considerable number of children with this syndrome are in need of help. Again a great deal of research, trial and error and specific methods have been tried, some touted as being successful while others have made little or no impression. In England the approach is of the formal educational type. In the United States a strong behavioral modification approach is used. However, Lovas who was an ardent believer in this approach admits to its limitations. DesLauriers-Carlson (1969) used a "therapeutic-educational approach which focused on the totality of the autistic childs patterns". Blackstock (1983) observes that "the great variability among autistic children makes it impossible to prescribe either a specific treatment or a specific educational approach that will be suitable for all autistic children."

Since it is felt that a combination of therapy and education is effective in most cases "Theraplay" as espoused first by DesLauriers-Carlson and later by Jernberg (1979) is a good model. Play is central to child development and to the development of symbolic functions as a basis for language development. Autistic children must be taught how to play. Again to quote DesLauriers "the most effectively impactful pattern of sensory-stimulating experiences for the child could be found in a play situation, where excitement, novelty, surprise and fun had the total arousal value needed to bring about a meaningful affective response."

Placement in regular preschools or day cares is chancy at best. Although they desperately need exposure outside their limited home environment, to find an appropriate compromise is indeed a challenge. Ideally a small non-threatening group of children with skilled providers is needed to bring these children to their potential.

In the beginning no particular effort is made to "teach" the child. The child must first know that it is okay to be with another person and eventually that it can be fun. Initially, an autistic child needs space. However, sitting at a distance, moving a bit closer day by day he soon learns that one thing can be substituted for another, that it is alright to allow an adult to have a turn, even tentatively touch his hand or make rearrangements without total devastation to orderly patterns and rituals. These rituals provide little fun but give a degree of security and should be allowed to fade gradually. Shapiro (1979) wisely observes "with autistic children therapy at its best is education and education at its best is therapy."

Long Term Goals

1) Help the child become a happy acceptable member of society.

2) Teach him to compensate for his handicaps.
   - Show ways of coping.
   - Develop skills which he possesses (to help him avoid frustration over the things he cannot do).

3) Help him towards a positive role in life as an adult.

4) Help him to increase his understanding of the world, to produce some order amid the chaos and allow him to find some pleasure and enjoyment in life.

Short term goals to arrive at long term goals must be continually revamped as success is accomplished. Start where the child is now and proceed. Continued success is only assured by continual review.

Getting Attention

- Reduce distraction
  - a) other people
  - b) noise
  - c) visual (e.g. clutter)
- Move to a face-to-face position.
- Get eye contact
  - a) say name or look! and leave a silence
  - b) use interjections e.g., oh!
  - c) touch
  - d) change pitch - vary intonation - try singing the name
  - e) bring an object to face level

- Bring out something new or start a new activity.
- Make an unusual sound or noise, or action.

Keeping Attention

- Be interested
    - a) interact or talk about something that is relevant to the child e.g., something he is interested in or about himself
    - b) stay with the "here and now" - ongoing action
    - c) talk at the child's level of understanding- particularly if explaining or planning
    - d) be lighthearted - funny, silly
- Keep it short - stop before the child looses interest if you can anticipate or immediately on loss of attention.
- Switch - conversation, materials, tasks when the child is tiring.
- Use social re-enforcement, i.e., smile, nod, respond to what is said, reflect non-critically on what is implied but not said, keep your voice interesting and pleasant.

Basic Management

Shaping	- accept any response that is a near approximation- gradually require more and more precision.
Chaining	- teach consecutive steps in a task - (task analysis).
Reverse Chaining	- start at last step, work backward to beginning.
Fading	- gradually reduce the aid or the cues, letting child do more and more of a task.
Use of "No"	- no itself can be reinforcing.
	- try to limit comments to correct behaviour.
	- direct and assist response so it will be correct and positive - give only the amount of help needed.

General Suggestions

- Will learn behaviour which is rewarded.
- Will refrain from behaviour which has unpleasant results.
- break down into tiny steps

(Task Analysis) (Reverse Chaining)

- Making sure that he succeeds with each small step will avoid the upset of failure.
- Encourage him to try a new skill by prompting him, fairly obviously at first, then less and less as time goes on. Model for him to imitate but remember that imitation for him is difficult and may be impossible.
- Link new learning with skills which are already familiar and which give pleasure.
- Ignore irrelevant behaviour. Immediate reinforce correct or acceptable responses consistently.
- Use name only with things that are pleasant and positive.
- Refusal to become involved in a task usually indicates a lack of understanding and will lead to resistance, anxiety, temper tantrums, bazaar behaviour or withdrawal.
- Repetitive linking is necessary until responses are somewhat automatic and must be reviewed regularly.
- Although behaviour is difficult to understand, there is usually a concrete logical reason behind it.
- May not learn "yes" until 8-9 years and sometimes uses no for everything.
- Needs to be taught mime (cannot develop himself) and gestures (pretending to comb hair, drink from a cup, etc).

Management Strategies

Vital - To like him, be concerned about him and really have his best interests at heart.

- know the child.
- understand his handicaps.
- be aware of likes and dislikes.
- be able to guess what he intends to do before he starts to do it.
- reinforce at once and consistently.
- prevent undesired behaviour; if impossible take action as soon as possible the behaviour starts - once he has had the fun of doing the forbidden act, it is very difficult to intervene. Use

distraction, develop a strategy, physical restraint or force causes panic.

- act quickly (or second guess) everytime he begins to show the difficult behaviour.

behaviour which cannot be anticipated or prevented, ignore and remove your support - be sure you can move in and actively reinforce the stopping.

- should behaviour become obsessive, build a group of verbal commands to end it, eg. stop it (sharply) followed by OK in a softer tone. This could gradually be replaced by a touch on the shoulder or a particular facial expression. It will be important to monitor for inappropriate imitation.
- in order that the above be effective, he must be helped to find positive, constructive things to do.
- must take time to help him understand the situation.
- follow stages in correct sequence.
- build on his readiness in any area and on what he is successful with.
- do not use toys which complicate language or imagination.
- needs order and pattern (to reduce his ritualistic behaviour which is his attempt to keep order in his chaotic world, eg. twirling hands, repetitive language, obsessive play).
- in extreme cases, a firm stand must be taken although it may cause much upset and may be a lengthy process.
- it is easier to eliminate inconvenient/inappropriate habits as soon as they appear, than to let them develop over time and then try to discontinue them.
- compromise between too much rigidity and too little structure.
- you cannot assume that he is able to name even the simplest object unless specifically taught - name things giving time to repeat.
- tickling, joshing, helps to keep him "in touch".
- remember he is unable to predict consequences of things that happen.
- more likely to produce words if you do not supply all his needs

before he has tried to say anything.

- try singing words to him.
- needs help in generalizing - may not understand that "chair" applies to more than one specific shaped chair; circle may apply to anything round.
- teaching correct response. eg.,

Adult: The cow says "moo"
What does the cow say?
The cow says "moo"
Adult: Repeat (using reverse chaining method)
Adult: The cow says "moo"
What does the cow say?
The cow says ______

- Child supplies "moo". Proceed with reverse chaining.

must be taught outward expressions for inner feelings.
- smile, frown, etc.: use pictures, mirror.

- encourage "looking at you" activity, task, make faces at him, whisper, sing, (your own trick) touch noses and twist your head, laugh, pat, reinforcement on task or activity.
- needs support with other children; does not have verbal wit or physical skills (and does not learn through experience) to hold own among peers.
- indiscriminate friendliness needs fading:
  - switch from hugging to touching, holding hand, or arm around the person.
  - hugging reserved for family.

Medication

To date research and experimentation on possible medication for these children have not produced promising results. However, some recent studies have provided interesting results that may in fact lead to help in this regard.

SUMMARY

Over the years autism has sparked much interest and research.

While it has supplied vital information and added general understanding, it has also emphasized the complexity of the disorder. These children suffer severe deficits, present unusual behaviors and usually have very limited understanding of their world.

Autism is now considered as having multiple causes. To date research has made limited progress in this respect. Prognosis is guarded. However, early diagnosis and intervention has shown promise.

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CHAPTER 7

DEVELOPMENTAL LEARNING DISORDER

7 DEVELOPMENTAL LEARNING DISABILITIES

The term "learning disabilities" was first used by Kirk in 1963. In addressing the problems of the perceptionally handicapped child, he proposed that the term be used for children experiencing difficulties in basic skill areas. The definition recommended by him reads as follows:

> "Children with special learning disabilities exhibit a disorder in one or more of the basic psychological processes involved in understanding or in using spoken or written language. These may be manifested in disorders of listening, thinking, talking, reading, writing, spelling or arithmetic. They include conditions which have been referred to as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, developmental aphasia, etc. They do not include learning problems which are due primarily to visual, hearing, or motor handicaps, to mental retardation, emotional disturbance, or to environmental disadvantages".

As we shall see, more recent research has questioned many of these assumptions. There remains to the present, a great deal of controversy and confusion. In any event, the concept of learning disabilities has brought about a greater awareness of deficits in children. Strengths and weaknesses vary greatly from child to child, with many exhibiting several dysfunctions simultaneously. In a considerable number of cases combinations of behavioral, cognitive, motivational, social and learning deficits are exhibited.

Children with learning disabilities often are not so different from their peers. They cannot be identified by their appearance and in many instances, initially behave similarly to same age children. The difficulty in sorting out whether the child has learning disabilities or is simply unmotivated strongly suggests the need for an in-depth assessment to arrive at a differential diagnosis. Information gleaned from a thorough assessment is essential in understanding the child and his specific areas of difficulty in terms of treatment and management.

Most people, when referring to or discussing learning disabilities think only in terms of school-age children and adults. Others, who have studied and worked with preschoolers believe that the term developmental learning disabilities applies appropriately to preschoolers as well. In 1985 at the National Joint Committee on Learning Disabilities it was stated that "preschool children demonstrate specific developmental delays or deficit patterns that are early manifestations of learning disabilities. These include atypical patterns of development in communication, perceptual-motor abilities, cognitive abilities and/or social and personal behaviors that adversely affect later academic learning". Children with these disorders may not develop ordinary language, visual or auditory skills despite normal vision and hearing, nor do they learn by the usual teaching methods. Although these children show a great deal of variety in their learning problems, they do have one characteristic in common, that of uneven abilities in the various developmental areas. A child may have above average language skills while experiencing a severe delay in motor skills or vice versa. This scatter or discrepancy interferes with the child's learning processes. As well, this unevenness in development works against the child's successes in life in that these children may be suspected (inaccurately) of not measuring up to their capabilities when in fact they are dealing with situations that make no sense to them. In unknowingly pushing a child beyond his capabilities, his inability to understand and respond may be construed as obstinate, uncooperative or even retarded behavior.

Emotional and Behavioral Reactions

The child with developmental learning disabilities usually has a basic neuropsychological immaturity in functions such as temporal organization and spatial organization causing distortion in body image (orientation in space) and in concept of time. Regardless of their basic temperament or intellect, they all experience "repeated failure and frustration, with impairment of their self esteem. The resulting psychiatric picture may run the gamut of emotional and behavioral disability ranging all the way from withdrawal, school refusal, somatization, regression and depression on the one hand, to aggression, negativism, projection, clowning on the other" (Silver 1983).

Impulsiveness, Distractibility, Inattention and Hyperactivity

These behaviors are also seen in children with attentional deficits disorders (refer to chapter 3). Impulsiveness in preschoolers generally take the form of acting quickly without considering the consequences of their actions. They use poor judgement and planning, and tend to be reckless.

Distractible children have difficulty staying on task. Their attention is drawn to every sight and sound, and they are unable to refocus on the original task and may in fact quickly flit to many other activities. A related problem is their short attention span. They change activities often, never seeming to get satisfaction from any of them. They appear to daydream, leaving tasks unfinished.

A hyperactive preschooler is unable to focus attention on a task or direction, usually moves and talks much more than other children, is unable to block out events or unimportant happenings in his environment. They usually do not sit or stand for any length of time without fidgeting. Perseveration may also be noted. Children who perseverate repeat an activity over and over and cannot seem to stop. They may ruin their drawing because they don't know when they are finished or they may become mesmerized with running water, sounds or movements. They have trouble with "carry over" from a previous task. It should be noted that perseveration may also be seen in children with mental retardation or emotional disturbance and therefore careful identification is important.

In unfamiliar situations, all the newness bombards them. They are often anxious and sometimes this anxiety builds until they seem to "burst" into what looks like a temper tantrum. It really isn't... there is no temper only woe and suffering. They have difficulty waiting. Is it any wonder that their unpredictable and sometimes hostile and negative behavior leads to rejection by the other children. The associated bewilderment may result in the acceptance of feelings of inferiority or that of an unwanted person, affecting personality and attitude.

Motor Problems

Motor problems include **perceptual** motor difficulties (inaccurate information received resulting in poor co-ordination, clumsiness, awkward or stilted movements); difficulty in crossing the midline (moving one's limbs across the centre of the body eg., painting across the page without switching hands); **auditory motor** problems (following verbal directions, dancing to music) and **visual motor** difficulties. The child with visual motor problems will have difficulty with reproducing drawings or simple patterns such as a horizonal or vertical line, a circle or interlocked figures since they require a considerable degree of perceptual discrimination. Reversal of letters, numbers and mirror image printing are often observed. In more social situations, the difficulty extends to role playing and simple games or puzzles. They try to imitate but often do not understand what they are to do. They cannot join the play... they do not know how.

Perceptual Disorders

These difficulties include deficits in auditory and visual figure-ground; visual and auditory closure; perceptual speed and perseveration (previously described) **auditory perceptual** problems refers to the difficulty of taking information in through the sense of hearing and/or processing that information. A sequencing or discrimination error can change the entire meaning of a message eg. formed may be heard a fourth. **Auditory discrimination** difficulties gives trouble with hearing the difference between similar sounds eg. "m" and "n", hearing an angry rather than joking tone of voice. An **auditory figure-ground** problem indicates the difficulty in hearing a sound over background noise eg. having difficulty hearing someone talk in a noisy room. **Auditory sequencing** problems refers to the difficulty of hearing sounds, talking in correct order.

Visual Perceptual Problems

Children who have difficulty seeing specific images within a simple completed background, seeing his mother in a crowd, or finding his mitts in the mitten box are having a problem with **visual figure-ground discrimination.** **Visual sequencing** refers to seeing things in the correct order. A child with this problem would have difficulty seeing things in the correct order, reverses letters, numbers and words. A **visual discrimination** problem is one where no discrimination is made between two similar objects, two shades of one color or similar letters (v as u). **Depth perception** problems refers to the difficulty of perceiving how close or far away an object may be eg. plunging a hand into the water tub expecting the toy to be on the floor or falling going down stairs after having misjudged the depth of the step.

Memory Disorders

Memory disorders include deficits in visual, auditory and haptic memory, as well as long and short term memory. They have trouble with remembering names, numbers and what happened a few minutes ago. They can also have difficulty with word finding or recall.

Cognitive Problems

Thinking deficits include deficits in concept formation, problem solving, cognitive sequencing (thinking in a logical, orderly way-tendency to jump to conclusions), cognitive discrimination (trouble distinguishing between two similar concepts eg. love and like, argue and fight).

Spatial Orientation Problems

DLD children not only have problems with their own need for space, they also have difficulties with organizing things in space. They have difficulty with drawing a person, having no conception of body parts and may have trouble telling the position of their limbs with their eyes closed. As they grow older they have problems with left, right and in finding their way around the neighborhood.

Language Disorders

Language disorders include deficits in integrative, receptive and expressive language as well as delays in developing semantic, phonology, syntax and pragmatics.

Psychosocial Problems

Problems such as poor task orientation, dependency, acting-out and inappropriate social behaviors are common in children with developmental learning disabilities. Usually these problems are present from an early age and if not remediated may persist into adulthood.

Adjustment to new situations are difficult since they are unable to organize the new environment into a pattern to which they can relate. Rules are beyond them and therefore they cannot follow them. The inability to recognize the meaning of the behavior of others (body language, distance, verbalization, clothing, facial gestures etc.) reflects their social perceptual problems.

While different research findings have produced slightly different information on developmental learning disabilities in preschoolers, the number of areas that may be affected as well as their impact on still other areas confirms the pressing need for identification and remediation.

Causation and Prognoses

For many years definition and research on learning disabilities, assumed that processing deficits were a reflection of "dysfunctions of the central nervous system". More recent information (Taylor & Fletcher 1983) suggests that genetic or biological factors contribute to developmental learning disabilities. However, the exact causes of this disability remain largely unknown. Environmental issues must also be considered including lack of facilities or willingness to accommodate individual needs or learning style.

According to many estimates the prevalence of learning disabilities shows that between 5% to 15% of school-age children are affected. Since the focus has only recently begun to include preschoolers, it would be reasonable to expect a similar prevalence at the younger age. Males are more frequently identified at a ratio of 5:1.

"Remediation at an early age does not alter the genes and probably does not regenerate brain cells. What it does do is to fill in the functions from which the child has withdrawn" (Kirk 1987). If we start with children at an early age the prognosis for overcoming these difficulties (in part or totally) before public school entry is encouraging.

Associated Behaviors

Impulsive behavior

- running
- loud and incessant talking
- blundering into peer play
- recklessness (limited awareness of danger situations)

Attentional difficulties

- doesn't indicate that he hears
- is distracted by "outside" noises
- gets drawn into loud or busy peer play
- has difficulty sticking with or returning to a task

Hyperactivity

- gets carried away after 5-10 minutes in fluid play such as sand (throws it), water (splashes) or painting (spills)
- cannot sit (stands at pasting or playdough table)
- constantly fidgeting
- never walks if he can run

The above behaviors often overlap with that of the ADHD child - see chapter 3 for additional information. Additional behaviors may include:

- Difficulty with labeling (recall or word finding), often gives associated answers
- Cannot carry out a 2-3 part direction. Asks for repeats
- Bumps into objects
- Can't balance on one foot
- Poor fine motor, grasp of pencil - immature drawings
- Misjudges distances
- Difficulty with concepts (in front, behind, under etc.)
- Confusion in recognizing shapes and sizes

- Poor scanning (notices details but misses main point in picture)
- Over-excitable in play situations
- Slow in finishing tasks
- Distinct and sudden mood swings
- Variability in performance from day to day (one day knows colors, next does not)
- Poor problem solving, can't make decisions

Very often these children are seen as naughty and misbehaving by both parents and teachers. How often have we heard "they are not realizing their potential"? It is assumed that they are not trying and that they are able to behave differently, when in fact their lives are filled with rebukes and punishments. They feel that they cannot do anything properly and that people dislike them.

TREATMENT AND MANAGEMENT

Early recognition of a child's developmental learning disabilities is necessary for appropriate treatment as well as long-term follow up. Effective treatment must consider all needs of the child. Usually programs tend to be inadequate in scope and intensity. If a child has not already been diagnosed and is showing a considerable number of the following indicators a referral should be made immediately.

- Uneven development
- Visual/auditory difficulties
- Poor body image
- Language difficulties
- Poor gross or fine motor
- Perseveration
- Impulsiveness
- Distractibility
- Short attention span
- Hyperactivity/withdrawal
- Low self esteem
- Conflict with peers.

An in-depth assessment to identify "the gaps" is essential to provide individual treatment and management. The goal of assessment is to provide a hypothesis on the major deficits responsible for the child's difficulties.

Long Term Goals

1) Promote independent functioning and a strong sense of self.
2) Remediate "gaps" in development.

Develop short term goals to gradually achieve the long term goals. Develop a program with the child's specific deficits in mind, begin at the child's level and proceed.

General Suggestions

- The DLD child needs an environment that has limited auditory and visual stimulation (quiet corner, a quiet room to retreat to, part of his day spent in a small group or in a 1-1 situation.
- Provide structure and direction (simplify activities, materials, limit number of alternative responses/choices, be concrete, do not overload the child).
- Use direct teaching: DLD children cannot benefit from discovery methods.
- Individual instructions (teach the child mastery through achievement at his level - this may involve "overlearning" for better retention.
- Promote motivation (incentives, rewards or praise. This must be carefully done to avoid over-involvement with the reward only).
- Teach to all deficits (the child must receive help in all areas of deficit so that he can become an independent learner).

Management Strategies

- Get past his difficult behaviors, study his deficits, observe his frustration and sorrow, get to like him, accept him.
- Get to know him, understand him.
- Be aware of his strengths and weaknesses.
- Take an interest in helping him overcome his handicaps.
- Do what you can to adjust his environment.

- Give explicit instructions and modeling.
- Guide him step-by-step.
- Use concrete aids and strategies.
- Keep attention focused for short periods with interesting activities related to his deficits.
- Monitor his responses and provide feedback.
- Make incentives contingent on improved performance.
- Give him plenty of time to get rid of tension and restlessness.
- Teach to specific difficulties (as discussed earlier) - be creative.

Unfortunately research has not been able to pinpoint any one method or preferred program for all learning disabled children. Each child appears to have his own way of learning. However, the way in which a developmentally disabled child is taught has a direct bearing on their development.

Medication

The child should have a complete medical, including such testing as an E.E.G. CT scan, and an in-depth neurological workup. Evidence to date does not support speculation that learning disabilities are a direct result of such things as allergies, sugar intake, salicylates or vitamin deficiency although they could, no doubt, exasperate the problem. Learning disabilities are sometimes treated with stimulant medications. It is important to monitor and evaluate the effects of medication on the child's behavior and cognition.

SUMMARY

Samual Kirk first used the term "Learning Disabled" in 1963, later changing it to "Developmental Learning Disabilities" in referring to preschool age children. Stated casual factors usually include organic and biological, environmental and genetic. There is no scientific evidence available to indicate that learning disabled children necessarily have brain injury or dysfunction.

In-depth assessment is encouraged as a means of providing precise measurement of deficits and behavior. The most frequently listed difficulties include hyperactivity, impulsivity, perceptual - motor impairment, coordination deficits, inattentiveness, emotional fragility, thinking and memory, visual and auditory perception, social adjustment problems. They may also show indications of neurological difficulties and/or EEG irregularities.

Since it has only recently been accepted that preschool children can be assessed for indicators or actual developmental learning disabilities, few programs for this age group have been established. However, research tells us that effective and appropriate intervention at this early age can do much to remediate the deficits by the time the child begins kindergarten.

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PART IV

PERSONALITY AND EMOTIONAL DISORDERS

CHAPTER 8

CHILDHOOD DEPRESSION

"A healthy self-environment relationship can lend to the experience of a sense of ordinary well-being. Disturbance of any conceivable sort may lead the developing organism to perceive loss of a healthy self-environment relationship. This perceived loss, in turn may lend to the loss or diminution of the sense of ordinary well-being" (French 1979). Although research on childhood depression has only become more popular during the last fifteen years, Spitz in 1946 discussed "anaclitic depression" in infants who were separated from their mothers. Reactions took the form of sadness, withdrawal, slowed movement, apprehension, limited or delayed reaction to external stimuli, loss in weight and appetite and sleeplessness. Anaclitic depression is seen as a result of object loss, (mother or caretaker) an environmental event.

A recent review of the literature indicates that the existence of childhood depression (other than depressive states in infants) is now appropriately being recognized. In a study done by Cytryn and McKnew (1974) three forms of childhood depression based on clinical manifestations were reported, namely, masked depressive reaction, acute depressive reaction and chronic depressive reactions of childhood.

Masked Depression reflects such behavior as hyperactivity, poor social adjustment, aggressive and disruptive behavior. However, on a one to one basis these children reveal their depressive mood, are usually apathetic and sad. They regard themselves as stupid or dumb, feel peers are picking on or laughing at them. Their play and projective testing reveals fears of annihilation, violence, explosions, fantasies. Drawing and verbalizations further indicate defective body image, feelings of inadequacy and helplessness. If not treated these symptoms can develop into even more serious acting-out and aggressive behaviors which may require residential treatment.

Acute Depressive behavior characterize withdrawal, sleep disturbance, failure, depressed affect, severe separation anxiety. Closer examination could reveal sadness, tearfulness, slowness of movement, despair, and hopelessness.

These symptoms usually are tied to a traumatic environmental event such as the loss of a parent(s) (particularly mother) or a significant other. Unless there is a history of loss or other traumatic events, these children usually respond positively and relatively quickly to appropriate treatment.

Chronic Depression in childhood is severe in pervasiveness. These children are plagued with insomnia, refuse to eat, have severe weight loss, experience screaming or weeping episodes and engage in threats of or suicidal attempts (which are particularly difficult to interpret due to the inability at this young age to be accurately expressed). Both mild self abuse and/or more serious attacks on the self reflect their feelings of "badness", worthlessness and of being unloved. Historical background usually points to on-going losses and separations in early childhood. As well, at least one parent has a similar background (neglect, violence, self-abuse, chronic depression). Treatment can help with more open expressions of anger leading to some improvement in mood, appetite and social interaction. However, unless there is marked improvement in the home environment, symptoms will reappear. The seriousness of this condition will probably need on-going or intermittent therapy on a long term basis.

Bowlby's (1973) classic description of attachment, separation and loss make clear the importance of the availability of responsive and helpful persons in the development of self-reliance. Without such a person to whom he can turn without hesitation at times when he is dealing with alarming or fearful situations, feelings of humiliation or anguish may result in the child developing an insecure or distorted personality. To quote Bowlby:

> "Yet a further difficulty turns on the fact that a mother can be physically present but 'emotionally' absent. What this means, of course, is that although present in body, mother may be unresponsive to her child's desire for mothering. Such

> unresponsiveness may be due to many conditions - depression, rejection, preoccupation with other matters - but, whatever its cause, so far as the child is concerned she is no better than half a parent. Then again, a mother can used threats to abandon a child as a means of disciplining him, a tactic that probably has an immeasurably greater pathogenic effect than is yet recognized."

The child with normal attachment will protest the mothers leaving, even try to pursue and shows anger or sadness. The depressed child is withdrawn, shows little responsiveness to the absence or the return. Response to depression depends on the child's age, (developmental stage) and changes over time eg. characteristics and behavior will depend on whether the child is developing symbolism, language, representation or abilities to think logically and problem solve. Regardless of the developmental stage, an important factor to acknowledge is that virtually all facets of the child's functioning will, in all likelihood, be affected.

Causation and Prognosis

Research has tended to focus on symptom characteristics. The causes (precipitants and antecedents) of depression including events contributing to the state as well as conditions which sustain these states have received very little attention. A variety of events taking place at various stages of development such as significant and continuous losses, rejection, fears of annihilation and violence could be causative. In many cases the precipitating cause was a severe trauma, associated with object loss. The literature is full of examples of the effects of parental behavior (particularly that of a depressed mother) on the child reproducing the mother's depression in him/herself.

Reports on the prevalence rates of children show large discrepancies. Investigators on childhood depression feel strongly that the problem is highly underestimated, particularly among preschool children.

Early detection followed by treatment and stabilization of the home environment point to a promising prognosis. With the more severe and pervasive cases - those children whose early life was a series of traumatic losses, with parent(s) also experiencing severe depression, prognosis is certainly more uncertain.

Associated Behaviors

- Inability to remain alert or participate in activities.
- Tendency to yawn, lay head on arms or lie down in a quiet corner.
- Disinterest in snack (any kind of food).
- Social withdrawal, aloneness.
- Indications of feeling of inadequacy.
- Hyperactivity, aggression, irritability (when closely studied may be masking sadness, apathy, helplessness).
- Difficulty separating from parent.
- Screaming episodes or temper tantrums.
- Complains of psychosomatic illnesses.

TREATMENT AND MANAGEMENT

Because of the different behavior in different depressive states, the need for psychological as well as biological assessment can be beneficial. When children exhibit several of the following characteristics over a period of two weeks or longer an assessment for depression should be considered.

- Agitated activity or extremely low activity level.
- Persistent fatigue, loss of energy.
- Indicators of feeling of worthlessness, inappropriate and excessive guilt and self-reproach.
- Joylessness, inability to experience happiness or pleasure.
- Change in appetite, sudden loss in weight.
- Sleep disturbances - excessive sleeping or complaints of wakefulness.
- Suicidal thoughts, threats or attempts.

Several modalities for treatment of depressed children have been developed. Generally a combination seems most effective. However, mode of treatment will depend somewhat on presenting symptoms. Of particular importance is family therapy. Research reveals that changes in the child's environment in terms of reduced threats and violence, increased acceptance, attachment predictable and availability of a caring adult is the most important factor in reducing depression in young children. Without such a change in the home environment, limited change will be made in the child's overall attitude. Individual therapy as well as group involvement will be needed to round out the treatment.

Long Term Goals

1) To help the child begin to overcome feelings of annihilation, hopelessness, and despair... to inject some joy and reason for living into his/her life.
2) Begin the child on the road to fulfillment as a reasonably functioning adolescent and adult.

General Suggestions

- The depressive symptom of reduced activities is attributed to reduced reinforcement from the environment. Although depressed children find it hard to tolerate even the most low key interaction, casual and gently praise or comment in response to any activity (even walking across the room) would be a place to start. In essence, reinforcement will be associated with decrease in depression.
- Similarly, depression has also been attributed to deficiencies in social skills due to poor social interactions. The goal would be to increase the child's ability to obtain reinforcement from others.
- These children tend to pay attention to negative events and have poor skills in self-evaluation and self-reinforcement. Emphasis needs to be on more positive cognitive processes, reinforcement, activity levels and reversed role of learned helplessness.
- Perhaps the most deficient area is that of the influence (negative and/or rejecting) relationships with significant others. Since the ability to be socially outgoing is usually missing, a strong focus should be on interacting, social adjustment and mastery of the ability to socialize.

Management Strategies

- Be available but not overwhelming.
- Accept the difficulty, be cognizant of what is involved -fear of rejection, self-depreciation, despair, inability to participate, feelings of worthlessness and helplessness.
- Cautiously and casually try to interest the child in an activity, starting with a quiet one (even for a moment - initial praise, reinforcement must also be very low-key and casual) and move to more active ones. Keep in mind the listlessness is real but can only be overcome with more movement and feeling of self-worth.
- Help the child to recognize activities that are positively reinforcing.
- Help the child become aware of mood (so that he can begin to help himself).
- Increase positive activities, decrease negative ones.
- Increase interactions with adults and peers particularly those that are more rewarding.
- Begin by engaging the child in concrete behaviors with others- imitating conversations, making or refusing requests, responding.
- Teacher models role playing, gives feedback.
- Plan activities around daily living, teaching skills with repeated practice until the child has learned the skill.
- Reduce learned helplessness by integrating activities that are readily successful.
- Self-Help skills can be taught by "reverse chaining" (see chapter on Autism).
- Reduce the child's tendency to get caught up in negative events.
- Help the child to recognize realistic responses vs self-blame, negative reinforcement, too much punishment.
- The child will need encouragement with social adjustment and appropriate social roles through non-judgmental explanation of feelings, some careful refection by the teacher directed to development of insight.

Medication

As indicated earlier, childhood depression has only recently been seen as a legitimate problem. Many of the medications which have been tried with children have been adapted from those used with adults. This has evoked some criticism. However, demonstrations have been fairly consistent in showing that some of the medications used have decreased depressive symptoms in children. Recently placebo-controlled and double-blind studies has confirmed this positive therapeutic effect. Family physicians or pediatricians are knowledgeable in this regard and parents should be encouraged to consult with them to provide a comprehensive treatment plan for their child.

SUMMARY

At the present time there are few empirical studies on the treatment of depression in young children. The status of this situation is rapidly changing. The interest in developing assessment techniques and the use of psychological testing has confirmed, without a doubt, that a significant percentage of young children do suffer from this disorder.

Generally, depression of several months duration can present itself in several forms. While "masked" depression may resemble other problems, a closer look behind the hyperactivity, aggressiveness reveals a more depressive picture. Impairments usually include poor social adjustment, loss of appetite and weight, sleep problems, feeling of hopelessness, despair and in its most severe form suicidal ideas.

With early, consistent and appropriate treatment including group, family and individual therapy prognosis for fairly rapid improvement is encouraging.

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CHAPTER 9

BORDERLINE PERSONALITY DISORDERS

9 BORDERLINE PERSONALITY DISORDERS

The term "borderline functioning" or "borderline states" refers to a severe form of childhood psychopathology. Although it is only during the past twenty years that its use has increased, descriptions of children with similar characteristics have been appearing since the 1940's (Mahler 1949, Beres 1956, Ekstein and Walerstein 1954, A. Freud 1965). This concept has often been misunderstood and misused being seen as a transitory state between psychosis and severe neurosis. In the last few years, however, there has been an increase in the literature (Chethik 1985, Rinsley 1982, Kernberg 1983) specifying this syndrome as a form of pathology in its own right. Although not specifically listed under childhood disorders in the DSM-IIIR, this disorder would be considered under Pervasive Development Disorders. According to Szatmari (1989), "The need for systematic investigations into PDD-NOS (not otherwise specific) is strongly supported... criteria for PDD-NOS are so non-specific as to be quite unhelpful."

The possibility of borderline conditions occurring before adolescence is a relatively new concept yet according to Bempard, Hanson and Smith (1979) there is a growing body of evidence which confirms the existance of this syndrome in preschool children. In applying this diagnosis to children, it is particularly important to establish definite diagnostic criteria through many sources due to the rapid changes taking place in the child's developing organism.

Distinguishing features of pathology in borderline children include multiple ego organizations, chronic, free floating anxiety, unintegrated self - other bonds, thought processes and content, reality span, interpersonal relationships, impulse drives, perception and fluctuation of functioning. The borderline child may exhibit varying degrees of pathology and may differ in severity but a pattern eventually emerges that differs from other childhood diagnosis. The diagnosis will only be made over a period of time as the pathology may not be evident in the initial screening. Some children may appear somewhat neurotic or even normal and it is only when observed over time or in an unstructured environment that the pathology emerges.

Kernberg (1975) description gives a clear picture:

> "low frustration tolerance and poor impulse control. Pleasant and intelligent when alone with an adult, they become uncontrollably aggressive or withdrawn in a group. They reacted to frustration with an extremely severe form of temper tantrum. Firm handling of their tantrums, which would be the treatment of choice for neurotic children, led these children into paranoia, panic and loss of contact. Only a loving, soothing attitude of a familiar, affectionate adult could resolve the tantrum. These children were interested in inanimate objects and animals (although they could be cruel to them) more than in humans."

In examining their backgrounds, they had difficulties in all stages of development, suffered from nightmares, compulsions, phobias, lies. They had disturbances in language, eating and motility. They display puzzling and contradictory behaviors - unimaginative or an overly rich fantasy world; overly sensitive or tactless; lie excessively or be completely honest.

Fluctuations in Ego Slate

These children experience marked and frequent fluctuation in ego. At times they can function normally "as if" they do have an intact ego. However, with the slightest stress (often without warning or any observable reason), the child disintegrates, flies into a rage and just as quickly these behaviors recede. Usually the regression is caused by changes in the adult/child relationship (an inadvertent rebuke or possibly a misunderstanding) or a change within the child. The return to secondary process functioning probably followed an apology and expression of empathy by the adult. Regressive fantasies are used in response to a perceived threat and usually carried a "double message". They are an attempt to master conflict and a confession of current inability to do so" (Bemparad et. al. 1979). These fantasies focus on themes such as "separation, bodily distortion, abandonment, disintegration and cannibalism" but these children do not seem to lose contact with reality or to experience fixed delusions but do show thought disturbance in a mild form. The rapid fluctuations in ego cause severe disturbances in object relations, thought processes and reality testing. There can be manifestation of bazaar behaviors (obsessions, phobias) such as believing planes will lift them and carry them away or obsessive washing of hands to remove the poison. Another unusual focus of thought content is the impractical store of knowledge. They may have great detail on subjects such as classification of reptiles, astronomy and other scientific subjects while they remain ignorant of everyday basic facts. It is believed that these topics provide security (and a means of escape) in a fearful and unpredictable world or may indeed be an area of deviant development.

Anxiety

Borderline children experience free floating chronic anxiety which is often diffuse and overwhelming. They appear incapable of responding to any anxiety signals and can only occasionally turn to a trusted adult for help. While the source of these anxieties may in most cases be diffuse, the source of danger comes from outside inducing fears of annihilation, separation, rejection, loss, criticism, disappointments, fear of the strength of their unmodulated wishes and affects such as love and hate, sexual and aggressive impulses.

Expression of these anxieties takes the form of intense fears, body tension, agitation or rituals and obsessions. However, these threatening anxieties last for short periods and are exhibited in pure form.

Interpersonal Relationships

There is a profound deficiency in this area. While these children wish to merge psychologically with a trusted adult, they are terrified of a loss of identity. At the same time they are often indiscriminating in their use of others to fulfill needs that should normally be handled by the child himself at his stage of development.

They need constant reassurance that their world is safe and only when they feel secure can they function normally and with considerable intellectual ability. Relationships tend to be intense but superficial. The person is valued for what he does for the child rather than for his friendship and concern and can quickly be devaluated. In the borderline child's search for emotional safety, the child mirrors or becomes one with anyone who will fill this need appearing to have no stable personality of their own. The child in hospital who is extremely upset with his visiting parents feels empty and sad when they leave. At such times of stress, he will try to merge with the nearest adult to relieve his anxiety and depression.

The borderline child does not usually get along well with peers. They can be threatening and cruel to younger children, fear older ones but with peers can be withdrawn, aloof and jealous, occasionally flying into rages attacking other children or themselves. At such times they may withdraw into fantasy to ward off reality or inappropriately demand exclusive right to the adult.

Sense of self and identity (may include gender identity) is unintegrated and vague. Feelings of inadequacies and particularly "badness" may prevail one minute only to be switched almost instantly to grandiose and omnipotent images of self. They do not understand the subtitles of social behavior, are often the butt of jokes, rejected and avoided.

Loss of Control

These children are unable to delay gratification, are uncontrollably aggressive and as noted early have difficulty with controlling impulses. Perhaps one of the most serious difficulties is their inability to inhibit frightening fantasies. In times of stress or frustration, anxiety takes the form of increased motor behavior, hyperactivity, agitation, aimless running, rocking or rambling talk. They may also rage and verbally or physically attack objects, other people or themselves. Although they appear completely out of control they can be calmed by a trusted, supportive adult. It is necessary to impose external structure to regulate frightening fantasies and his inner world.

Additional Symptoms

Physical appearance may be unusual, (poor coordination, unusual gait, stiff posture, stilted speech and odd manner). They have poor social awareness, often ignore personal grooming and are unpredictable in their response to new situations. Difficulties are noted in concentration, sleeping and attention. There is an unevenness of development. Bempard et. al. notes that "these children do present a conglomeration of advanced, normal, and grossly delayed behavior, all at the same time, with fluctuations between high and low levels of functioning in almost all areas.

Caution and Prognoses

Currently there is limited knowledge on the cause of borderline syndromes in childhood, the course of this disorder or what these children are like as adults. Although many cases have been studied and reported, minimal empirical clinical data on history or outcome is available. However, despite the diversity of reporting, the clinical descriptions are surprisingly and remarkably similar.

Organic impairment has not been tested out due to lack of extensive neuropsychological testing although these children do present with "soft" neurological signs. There is evidence (not as yet conclusive) to support hereditary or constitutional issues. Bradley's (1981) study found more separation from mothers or caretakers during the first five years of life than in other children, that borderline children often came from chaotic and unstable homes. While many of the parents experienced professional success, they had difficulty caring for their children.

The most encouraging prognosis for a favorable long-term outcome is an improvement in the chaotic family situation together with intensive psychotherapy. Frijling-Schreuder (1965) reports that improvement may be rapid if he feels understood or if handling of the child improves.

Associated Behaviors

- Fantasy doll play escalating to free association of themes of destruction and mutilation.
- Bazaar behaviors, rituals, obsessions.
- Difficulty concentrating, restlessness.
- Anxiety or frustration may result in rage, severe temper tantrums,

aimless running, rocking, or talking in a rambling manner.

- Panic states, withdrawal, regression or superficial conformity.
- React wildly to rejection, criticism.
- Monopolize a particular adult or conversely may be indiscriminate (approach strangers).
- Bully younger children, fear older ones.
- May attack peers, objects or themselves.

TREATMENT AND MANAGEMENT

Since these children present with such a wide variety of symptoms, appropriate testing would be helpful in arriving at an early diagnosis and provide guidelines in terms of treatment. The following list of traits together with earlier mentioned behavior will assist in making the decision to have the child assessed by professionals.

- Extreme fluctuations in ego state (sometimes appears neurotic).
- Reality testing is somewhat shaky (readily experiences intense anxiety in the face of separation, loss, rejection, criticism, demands, disappointments, humiliation and other frustrations).
- World appears unmanageable to them (often expressed in body tension, stiffness, agitation, or restlessness).
- Panic and inability to cope.
- Regression to primitive concerns and behavior.
- Aggressive impulses (anger, rage, negativism, sulkiness, fighting, cruelty and destructiveness).
- Antisocial behavior rarely accompanied with guilt. When guilt is expressed it reflects shame, humiliation rather than for disobeying a moral code or hurting others.
- Other unpleasant affects; greed, envy, jealousy.
- Difficulty forming interpersonal relationships.
- Problems integrating good/bad, closeness/distance. In close relationships there is intense feelings of aggressive impulses along with fear of hurting or being hurt (ambivalence).
- weak signal re anxiety causes (panic and feeling of being overwhelmed).

- Problems with impulse control and a tendency to take immediate action which often leads to serious threats to others/self.

The many deviations found in these children, their venerability and tendency to respond unfavorably to so many environmental or other interferences make it difficult to provide stable treatment and program planning.

Because of the pervasive deviances, a treatment plan should include individual psychotherapy, intervention in the child's social and educational situation. It is probably important that one person coordinate the plan and work closely with all aspects. Although these children do not do particularly well in group situations, a day program or placement in a residential setting is often indicated. Very often it is necessary to remove these children from the home for part of the day. It is also important to work with them in areas that are disturbed - group, peers, building relationships, self-esteem particularly since these children are often capable of high-level functioning.

Long Term Goals

1) To assist the child resolve internal conflicts.
2) Help the child develop appropriate behaviors and defenses as a means of adapting to his environment so that eventually he will become a functioning member of society.

This is a very long-term commitment since therapy will likely be required into adolescence, and intermittently throughout the lifespan.

General Suggestions

- Be aware of the possible rapid fluctuation in behavior caused by minimal stress and just as rapid reintegration following reassurance from a trusted adult.
- Bizarre preoccupation with fantasies are an attempt to keep irritational fears at bay. Try to normalize without confrontation or what might be considered criticism or rejection.
- Needs to be dependent on adult support. Give physical and verbal reassurance before distancing.
- Does not receive signals re escalation of anxiety (may be rapid)

based on fear of destruction, mutilation and annihilation. Few defenses in this regard, panics quickly. May need to be removed and again helped by adult.

- Distorts reality, manifested by obsessions, phobias, extreme dependency, merging and odd or grotesque and unusual fantasy themes. Again needs reassurance, acceptance and guidance back to more realistic play, thoughts.
- Excessive reliance on others to maintain inner security. Functions well with trusted adult.

Management Techniques

Vital - to understand Borderline functioning syndrome.

- Understand this child's difficulties and resulting behavior (get to know the depth and severity, the particular behavior of the individual child).
- Must be alert to the rapid shift in behavior, what they mean and how to handle them (to avoid further deterioration).
- Important to accept the child with all the wild and bazaar responses.
- Initially, may need to work with one adult to develop trust (this person, when trusted, will be seen as all good - will be devastated if criticized. Can be readily reassured with apology or show of understanding.
- Does not function well in a group or get along well with same age peers. Provide support, structure basic concrete play with one or two children for short periods.
- Needs to be removed when overwhelmed by anxiety. May need to be held and comforted or may need some distance with adult close by.
- Cognitive defects or inability to utilize intellectual talents in group situation will require one to one remediation at simple teaching level.
- A sense of mastery is important. A direct, matter-of-fact advice giving approach appears to be helpful as well as simple, clear tasks and goals.
- Obsession or proficiency in obscure areas of knowledge intrudes on

more practical level of learning. Introduce more useful information e.g., knowledge of reptiles could be complimented with introduction of farm animals, pets or other Canadian wild animals.

- Be aware that impulse control is poor - do not insist on waiting turns, delaying gratification until more stable functioning has been attained.
- With loss of reality contact, move in, reassure and allow child to "ego borrow". May only need to touch or briefly sit on adults lap.
- A calm, non-threatening stable and unconfused environment is helpful. Setting firm but not punitive limits provides security.
- This type of child is draining (although one must keep in mind the difficulties). As soon as is possible, the trusted adult must begin to share the load with a fellow-teacher. The child may never adjust as well to a second teacher (nothing to do with the teacher) but important to be able to "borrow" from more than one person in the environment.
- Can be indiscriminating (such a contradiction)! These children are not capable of a true relationship (again disappointing and often devastating to the trusted adult). Remember this is the best they can do - they need that someone to function!!

Medication

Generally, drugs for young children are unpredictable, complicated and not completely understood to date. However, there may be cases of borderline children (who show signs of hyperactivity or attention difficulties) where medication may be helpful. Since anxiety is always a major concern, antianxiety medication may be the drug of choice. A sense of mastery is essential to the borderline child and anything that can help him to gain control and reduce anxiety should be considered.

SUMMARY

The treatment of the borderline child is extremely complex and of long duration. Massive problems in fluctuation of functioning, anxiety, thought processes, control, and in relating to others need understanding and remediation.

An overall treatment plan is essential. The total constellation should included individual psychotherapy, day or residential treatment and education as well as parental therapy and guidance. In particular, therapy is long term in order to insure consolidation of gains.

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CHAPTER 10

CHILDHOOD SCHIZOPHRENIA

There has been much confusion over the years among professionals engaged in work and research on pervasive disorders in young children. Labels which have been used include autism, schizophrenia, psychotic, borderline. The overlapping (yet also distinct) behaviors and symptoms presented by these children are indications of the importance of a differential diagnosis in deciding on treatment and prognosis. These issues have provided a great deal of controversy regarding cause, conceptualization and treatment. Therefore, this chapter, while addressing schizophrenia directly, will make references to similarities and difference to other childhood disorders.

Historically, the concept of childhood psychosis (initially psychosis was used as an umbrella term for all disturbances in young children - more recently the umbrella reference has shifted to "pervasive developmental disorders" as espoused by DSM-IIIR), has followed that of adult classification.

More recently, with the significant increase (are we simply more aware) in childhood difficulties, independent studies have also increased. Early investigations by DeSanctes (1925) and Goldfort (1970) focused on neurological degeneration, which later was seen as inappropriate. Bleuler (1952) began the trend of investigating the results of "conflict and adaption as primary determinants" which followed his model for adult schizophrenia. As reported by Rucco and Newsom (1982) "there was widespread acceptance of childhood schizophrenia as a diagnostic category by the 1930's". At that time Patter's (1933) criteria included "1) a generalized retraction of interests from the environment; 2) dereistic thinking, feeling, and acting; 3) disturbances of thought, including blocking, condensation, perseveration, incoherence, and diminution of speech, sometimes to the point of mutism; 4) defective emotional rapport; 5) diminution, rigidity, and distortion of affect; 6) alterations of behavior resulting in either hyperactivity or immobility, or bazaar stereotyped behaviors. This was certainly a good starting point but much too broad resulting in the criteria being applied to a large range of children with symptoms of psychosis. Efforts at refining this information were attempted and in 1961 Creak provided diagnostic criteria which covers deviant behavior commonly seen in schizophrenic children and which has been widely accepted.

Another controversy surrounds the age of onset. Generally, it is accepted that there are several peak times for the onset of psychosis: before three years of age; late childhood; early adolescence. Recently there is a tendency to consider differences between early and late onset. It becomes abundantly clear that many more studies need to be done on this rare and extremely complex disorder. It has been noted that schizophrenia (all types including childhood) has been vaguely described in DSM-III as marked "by a strong tendency to retreat from reality, by emotional disharmony, unpredictable disturbances in the stream of thought, by regressive behavior, and in some, by a tendency to 'deterioration'". The fact that each schizophrenic child displays a unique set of behaviors, symptoms and characteristics make it difficult to give general descriptions. However, Ekstein's (1975) description covers many of the characteristics:

> "Characterized by such conditions as a break with reality, severely impaired reality testing, thought disorders of a primary nature (auditory or visual hallucinations, delusions, language systems in which there is often no clear separation between though, act, and impulse), constant returns to fusion states, and temporary, complete autistic withdrawals. The symptoms are similar to adult schizophrenia conditions except that in most cases the states of mental disorganization fluctuate and are thus often mistaken for borderline conditions."

Bellak (1979) also notes that

> "from a very early age the schizophrenic child suffers from extreme sensitivity and quickly regresses under stress. He is extremely vulnerable to separation, mild forms of rejection, and parental malfunctioning... There is extreme clinging to the parent and resistance to entering new situations and relations with people. In other instances schizophrenic children may be extremely submissive. Severe temper tantrums are common as is

> repressive behavior, including self-destructive behavior. Compulsive and phobic reactions are frequent, intense and often of a bazaar nature. Excessive sexual preoccupation with compulsive masturbation is often present. Sexual confusion and preoccupation with suicide and death may also appear."

The predisposition to this disorder in young children can be set off by trauma, an environmental event or a combination of several significant happenings. Take the case of Brian, who was a sensitive infant but whose development certainly fit the norm. At the age of two to three years several events occured: a rather serious convulsion, the birth of a sibling (prolonged hospitalization of the mother) and an unfortunate electrical shock producing profound changes in behavior characteristic of schizophrenia. There was withdrawal, bazaar ritualistic behaviors, breaks with reality, language impairment and loose associations. Aggression appeared in his limited but repetitive play (again, the overlapping of several behaviors reminiscent of other disorders, particularly autism). However, this young boy developed classic schizophrenic behaviors before long-term treatment effectively helped him deal with these difficulties.

DeMyer's (1971) criteria noted that "there are islands of normal relatedness or emotional dependency in a background of emotional withdrawal and flat affect... regression may occur to an autistic pattern".

Most of these bazaar behavior patterns, the short periods of "normal" relating quickly lapsing into thought distortions, the phobias, the sexual obsession have been confirmed in actual work with these children. Timmy (4 years of age) spent most of his waking hours drawing or painting. Although the drawing itself may have changed slightly (and only slightly) the theme and his explanation was always the same - the drawing depicted caves, huts occupied by huddled figures surrounded by hundreds of crosses. At each corner of the top of the picture, apparently fighting for dominance, were his version of the devil and God. Tim was desperately trying to make sense out of his chaos, and secure a safe place for himself. This demonstrates not only the thought disorder but also gives an idea of the desperation of these children. Stephen was terrified (and alternately fascinated) of the toilet, feeling that he was losing part of himself every time the toilet was flushed.

While there are multi-areas of deficits or distortion, only a few will be addressed in detail.

Withdrawal (the need for insulation)

The nature of this disturbance causes panic and excessive impulsivity (hyperactivity) which in turn requires emotional withdrawal. Such withdrawal seems necessary so that these children may insulate themselves from the stress being experienced in the environment, from parents, teachers etc. This is their only defense and the protective coating gained gives time to gradually develop a strategy whereby overwhelming emotional stimulation will be minimized. It is important for workers to understand that too early an attempt to intrude on the withdrawal could cause further distress and interfere with the insulation process. Moving in too quickly to show an understanding of the meaning of his actions may create more disorganization and confusion.

Social Behavior

Because of the narcissistic and fragile ego any attempt at socializing the child needs to be assessed in terms of his readiness. He will need to feel recognized and understood (slowly) by one person which he will perceive as having one other person in his self-absorbed and isolated world. He relates first on a narcissistic basis, then begins to investigate the reality of that other person (object relationship). Social relating as we understand it will be slowly developed in the schizophrenic child.

Irrational Fears

Ekstein has established the concept of fluctuating ego states in these children. Similarly, ego regression, especially in the extremely sensitive child responds to the many fears of the schizophrenic condition. Again Ekstein notes that "in their regressed state they produce markedly oral fantasies with such underlying themes as fears of separation, abandonment, or bodily disintegration and distortion of body image. Fantasies of giants devouring their victims and primitive outburst of rage were also characteristic".

Causation and Prognosis

The controversy over definition and description carries over to theories of etiology. Biological factors studied to date have not proven causally related. Maturational lag, genetic and congential factors are now considered more likely than social-psychological factors although to date there is very little concensis or empirical data to support any of the hypotheses. Sex distribution is the same for both sexes. Schizophrenia is considered to be very rare in young children with the incidence being 4 to 4.5 per 10,000 children in general populations.

Although there has been considerable progress in primary prevention, psychotherapy, educational methods and residential treatment, prognosis is guarded.

Associated Behaviors

- Wandering aimlessly with limited attempts at play.
- May suddenly panic resulting in running, pushing peers and adults (or even throwing of objects) in a paniced, frenzied manner.
- Sudden fear reaction to objects (toilet, new toys) or stimulation (sudden noises, voices, etc.).
- Ritualistic or bizaar behaviors.
- Autistic-like withdrawal - loss of contact with reality.
- Continually talking in a disconnected manner or to illusionary figures (visual, auditory delusions).
- Acts "as if" alone in the room (may acknowledge certain adults).

TREATMENT AND MANAGEMENT

Some investigations are now being done on infants who may be at risk. Fish (1971) reports on retardation of motor development and disturbances in body images. Other areas for early intervention include poor integration of perception, abnormal states of arousal, immature or disturbed social and affective development.

At the preschool level treatment would need a comprehensive plan including family, individual and specialized educational or group approaches or residential treatment. For children who have such severe disturbances (including cognitive and emotional) a high ratio of one to one or one to two would be required. These children will need to be encouraged to go through developmental stages. Such gaps as social interaction, appropriate response to the environment etc., will require careful planning and close co-operation with all agencies involved.

The initial task will be developing a relationship. Helping the child in any way possible to overcome intense turmoil requires psychological understanding and empathy to enable the child to risk emerging from his psychosis.

It is crucial that a differential diagnosis be made between autism and childhood schizophrenia if at all possible. In terms of treatment autistic children respond best to behavior therapy and education. On the other hand, the thought and affective disorder of schizophrenics respond best to a combination of psychotherapy, psychotropic medication and very specialized group experiences. The following list will assist in awareness of the disorder (four or five will be sufficient reason to refer the child for treatment and/or consultation)

- Breaks with reality
- Thought disorders (auditory or visual)
- Defective emotional rapport
- Distortion of affect
- Bazaar, unusual behavior
- Extreme sensitivity
- Compulsive and phobic reactions to seemingly normal situations
- Sexual preoccupation
- Antisocial behavior (or unawareness)
- Poor self-identity, body awareness

Long Term Goals

1) Help the child to develop inner controls (neutralize aggressive drives toward independence), distinguish reality from fantasy,

appropriately relate to others, facilitate identity formation, and build up protective coating, on his way to more normal functioning.

2) Gradually, with awareness of his difficulties, guide him in developing ways of resolving issues and providing cues (or be able to ask directly) to alert those in his environment of his plight.

3) Help him find an area in which he can be successful and which can provide some pleasure.

General Suggestions

- Since relating to others is a severe area of difficulty the choice of primary worker will be important. It will take studying the disorder, an ability to appropriately time interaction, be able to withdraw (but be close), perhaps hardest of all, be able to "wait" while the child develops his protective coat and be aware when interpretation may be harmful/helpful.
- The breaks with reality, the bazaar verbalization perceived as hallucination are often anxiety provoking. Keep in mind that they usually indicate that the child is at the prior stage to remembering. He may also be trying to deal with stressful events in terms of forgetting. Therefore, such activity may indicate that the child is in the process of developing verbal skills at a more advanced stage leading to imagining, remembering and thinking. It will be well to allow these hallucination but to encourage development of higher functioning (reality based).
- These children usually explore through play and other symbolic communication through repetitive (may be maladaptive) patterns to deal with his situation.
- Encourage him to employ signal anxiety and to become aware that significant people in his life can meet his needs.
- Be aware that these children are unable to evaluate people's reactions and sees everything in catastrophic proportions, particularly fear of punishment.

Management Strategies

- Become familiar with the intracies of the disorder. This will help your anxiety.

- Be aware that the feelings experienced by the child are those of loneliness, emptiness, depression, chaotic situations and feelings of confusion.
- Accept the anxiety, the bazaar behavior.
- Encourage withdrawal so he can begin to "insulate" and build gradual tolerance to overwhelming situations (to him).
- Allow him to use withdrawal as a means of inhibiting (you may have to use firmness once a relationship has been established).
- Help him acknowledge stresses so they do not build and overwhelm him (return to ritualistic and bazaar behaviors will be a clue).
- Extended periods away from family, especially mother may be difficult - he needs to "ego borrow".
- Provide structure to help appropriate behavior - cognitive tasks vs free play. He is unable to play, will wander or become stressed and bazaar.
- Develop inner control, decrease anxiety through play, repetitively if necessary. Keep interpretation to a minimum and within the play context.
- Provide limits... approach being "you are having trouble managing, I will help you".
- Help him to use toys etc., more appropriately eg. if phone is over stimulating, help him learn to dial, make conversation.
- Encourage concrete imitative play (usually not capable of imaginative play - their own fantasies may cause fear and panic).
- Establish a safe, protective, regular and consistent environment.

Medication

Some psychotropic drugs have been effective in treating childhood schizophrenia. Target behaviors include aggressiveness, sleep disorders, hyperactivity. Attempts to control anxiety, bazaar and disordered thought processes to facilitate more appropriate functioning is an important aspect. There are some side effects which must be taken into consideration and monitored carefully by all persons involved.

SUMMARY

Childhood Schizophrenia is a rare and complex disorder not fully understood in terms of cause, course, most effective treatment or prognosis. Genetic, biochemical and congenital factors are currently being considered.

The pervasive character of the disorder effects the child adversely. He is unable to respond to his environment appropriately or to the people in it. Further, the fears, anxiety and breaks with reality are overwhelming and frightening.

Although prognosis is guarded, results from treatment which includes psychotherapy, psychotropic medication, milieu therapy and/or residential treatment is encouraging.

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GLOSSARY

Aggression: An instinctual drive motivating all hostile and destructive behavior. In Hartmann's theory, through neutralization, this drive energy of aggression changes from instinctual to the non-instinctual mode.

Defense Mechanisms: Unconscious intrapsychic processes serving to provide for emotional conflict and anxiety. Some of the common defense mechanisms are: denial, displacement, dissociation, identification, projection, rationalization, regression and substitution.

Drive: A genetically determined, psychic constituent which, when operative, produces a state of psychic excitation or tension.

Drive-reduction: The tension from the drive impels the individual to activity aimed at eliminating the tension.

Ego: The ego serves to mediate between demands of primitive instinctual drives (id), of internalized parental and social prohibitions (superego) and of reality.

Egocentric: Excessive interest in and love of self.

Libido: Instinctual energy manifested in sexual drive. A drive state which undergoes neutralization as it changes from the instinctual to the non-instinctual state.

Object Constancy (Permanence): Realization that objects enjoy a relatively permanent existence quite apart from one's immediate perception of them.

Object Relations: The emotional bond between one person and another, as contrasted with interest in and love of self. Usually described in terms of capacity for loving and reacting appropriately to others.

Organic Mental Disorder: Transient or permanent dysfunction of the brain, caused by a disturbance of physiologic functioning of brain tissue at any level of organization - structural, hormonal, biochemical, electrical, etc.

Primary Process: In psychoanalytic theory, the generally unorganized mental activity characteristic of the unconscious. It is marked by the free discharge of energy and excitation without regard to the demands of environment, reality or logic.

GLOSSARY Cont'd:

Schizophrenia: A large group of disorders, usually of psychotic proportion, manifested by characteristic disturbances of language and communication, thought, perception, affect, and behavior which last longer than six months. Thought disturbances are marked by alterations of concept formation that may lead to misinterpretation of reality. Mood changes include ambivalence, blunting, inappropriateness and loss of empathy with others. Childhood schizophrenia usually appears before puberty. It is frequently manifested by autism and withdrawn behavior; failure to develop an identity separate from mother's; and general unevenness, gross immaturity, and inadequacy in development.

Symbolic Meaning of Play: The act or process or representing, in play, an object or idea by a substitute object, sign or signal.

Thought Disorder: A disturbance of speech, communication or content of thought such as loosening of associations.

Transference: The unconscious assignment to others of feelings and attitudes that were originally associated with important figures in one's early life.